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# A Plurality of Births: Languages, Places, Communities

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# AIMS

## The Association for Improvements in the Maternity Services

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Editorial

# A Plurality of Births: Languages, Places, Communities

*by Luisa Izzi*

Disclaimer: The following piece includes personal views and political opinions that are solely my own.

Almost a year ago, I suggested a theme for one of the AIMS Journal issues focusing on how "foreign" women and parents living in the UK experience pregnancy, birth and parenthood. In my mind, we would have offered articles relating to the particular cultural traditions of some communities surrounding pregnancy or birth, or explored the challenges faced by non-English speakers when navigating the maternity services. I thought of the great article published in a previous AIMS Journal issue about the use of Rebozo in an NHS setting[1] and wondered if we could find more examples of similar "non-native" practices. The way in which this issue has eventually shaped itself is somewhat different from what we had originally envisioned. We hope that it offers an interesting cross-section of the complex realities that "foreign" people face when having their children in the UK, and raises questions about how true communities of people are born.

The first question I asked myself was one of terminology. To name things is often to define them and to start a process of understanding, but there is no consensus on what to call people – like myself – who are not UK nationals and live in the UK. Are we migrants or immigrants, foreign-born, foreign nationals, or expats? An interesting briefing by The Migration Observatory at the University of Oxford, titled "Who Counts as a Migrant? Definitions and their Consequences"[2], underlines how the use of such a broad terminology can be problematic for collecting data, but also how different words can be differently loaded in the public discourse, often mixing issues of immigration status, race, ethnicity and asylum. Needless to say, the public and political discourse around these issues in recent years has been particularly charged, so our understanding of what these words mean can be particularly important.

Apparently, an immigrant is someone who travels to reside permanently, to settle in a different country, while a migrant moves for a shorter period of time, often to find work. So, in my case, I started as a migrant and turned into an immigrant. But is the UK my home? Do I feel "settled" here? Technically and legally yes, but this first layer of meaning betrays a more profound sense of "feeling at home," a feeling that many pregnant women and people cannot really share, for a variety of reasons. Do people really feel at home when giving birth in the UK, or has the prevalent model of birth become an unfamiliar and almost foreign land, even for English speakers and UK nationals? As our commissioned articles will show, there are still many stumbling blocks on the road to equality and dignity for all users of maternity services in the UK. This is a country that prides itself on its multicultural diversity, but the feeling I am left with is that multiculturalism and diversity are only truly "allowed" if they can be moulded into a narrow range of predetermined parameters. There is still work to do in order to break the mould and be our unique selves during pregnancy, birth and parenthood.

The birth of a child often kindles in the new parent(s) thoughts about the connections with their own family and native country. For someone who is becoming a parent in

a "foreign" land, looking for their own roots and providing new roots for their children can be a challenge. A sense of community, identity, or the shared experiences of childhood can be found in people who come from a similar background, or in new communities. Furthermore, mixed families, who live in the UK and come from two (or more!) different native countries or cultures, might feel an even stronger sense of displacement when having children, as they have to navigate multiple sets of everything: languages, traditions, cultural opinions and advice from families and relatives, etc.

It is really difficult to paint an accurate picture of the situation, one that is not affected by personal experiences and perceptions. At the same time, even I – a white woman with very good English and a higher education, the walking example of privilege – cannot shy away from often being "othered" as the Italian in the room, and I constantly have to decide if I want to embrace the clichés or affirm my individual identity, regardless of the colours of my flag(s). Even though I have been lucky to have never experienced open racism directed at me or my family, Brexit has emphasized in me a sense of not belonging to the country I have been living in since 2006, a feeling of not being fully wanted or accepted. At the same time, there are many reasons why I am grateful for having given birth to my children in the UK as opposed to Italy. A case in point is that in Italy, the option of giving birth at home is limited to four cities that offer a free midwifery service in collaboration with the National Health Service, and four regions and two provinces that offer partial reimbursement for private expenses.[3] In the UK, despite medical support for a homebirth sometimes being hard to come by, it is a legal option for all women and birthing people and recommended as such by NICE guidelines.[4]

How do these musings translate into the June issue of the AIMS Journal that you are about to read? We have gathered a very diverse group of articles that explore how communities – built around culture, countries, languages or even just like-mindedness – can be a powerful place to share experiences of pregnancy, birth and parenthood. The same communities can also be extremely marginalized, and can face huge obstacles in accessing services with equity and equality.

Sophie Davies takes us on an eye-opening journey, exploring the barriers that people from the Gypsy, Roma and Traveller communities face when navigating pregnancy and birth and providing some suggestions on how to facilitate not only better access, but also more dignity in the antenatal and postnatal care within these communities. Siteri Tui Kurewaka offers us a wonderful picture of the experiences and traditional celebrations surrounding her pregnancies, births and motherhood as a proud member of the Fijian community in the UK.

Beth Whitehead's harrowing personal account is a stark reminder of the trauma that can occur when an almost universally intuitive approach to birth and parenthood is denied in favour of a "conveyor belt system," where individual choices are crushed into a one-size-fits-all mould. The lively account by Martine Monksfield leads us through the world of a Deaf Mum navigating three pregnancies, with all the incomprehensible inconsistencies in providing suitable assistance to make her journey more Deaf-friendly/user-friendly, and some positive changes she has seen along the way.

Zori Jeffries's work as an interpreter supporting Bulgarian women during pregnancy and birth is inspiring and fast-paced, and it highlights how language and cultural differences can be problematic when "lost in translation". Emily Carson challenges our perception of another kind of language which is often left unheard or misunderstood, the language of the individual body, which people – especially during pregnancy – can be socially and culturally primed to silence.

The themed articles are followed by the pieces curated by the AIMS Campaigns team. Jenny Chambers's experience began with her medical condition, Intrahepatic Cholestasis of Pregnancy, but developed into a true community of people, a charity, and the scientific validation that comes from involving patients in research on their own condition. This piece is followed by the fascinating interview with Dr Kuldip Bharj, OBE, who has spent over 40 years of her career in midwifery, including roles in education, research and practice. Shane Ridley comments on the 2019 MBRRACE enquiry into stillbirths and neonatal deaths in twin pregnancies, highlighting the standard of care that should be guaranteed to people expecting twins. In 'Where Next for Better Births in England,' the AIMS Campaigns

team reflects on the Better Births Five Years On event, including the full version of Julia Cumberlege's speech, as she has played such a pivotal role in the whole initiative. The Campaign update on Coronavirus and the maternity services continues to keep us informed on how the Covid-19 pandemic is affecting maternity services.

We have included two film reviews in this issue. Birth in the 21st Century is an interesting and touching Spanish documentary, watched and reviewed by Rachel Boldero, while Megan Disley provides a lyrical review of the controversial film Pieces of a Woman, which is available on Netflix. To conclude, the Campaigns Steering Group presents a summary of their activities for this quarter.

We are very grateful to all our authors, to our peer reviewers – Verónica Blanco, Danielle Gilmour, Anne Glover, Anna Madeley, Millie May, Caroline Mayers – and proof readers – Judith Payne, Josey Smith, Zoe Walsh, Michad Wildman – to the fabulous Danielle Gilmour who uploaded all of the material to the website, and to all our readers and supporters.

We really hope you will enjoy this issue. In our next Journal coming in September we will be exploring an issue central to the AIMS ethos: decision making and consent.

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Article

# The Experience of Pregnancy in the British Gypsy, Roma and Traveller Communities

*by Sophie Davies*

Gypsy, Roma and Traveller (GRT)[1] women play a fundamental role within their communities and have distinct roles to men. Often seen as 'exotic outsiders,'[2] GRT women have historically been seen as 'sensual, sexually provocative and enticing,'[1] as well as 'passive objects, engaged in fortune telling and dealing with magical or medical potions.'[2] Up-to-date literature describes GRT women's roles as being mainly based around homemaking and caring duties.[3] It is fair to say that no other ethnic group of women has aroused such curiosity, mystery, hatred and fear in the UK.[4] Such interest continues to leave GRT women and their communities with wide-ranging inequalities[5] including large disparities in health care.[6]

GRT communities are the most excluded in the UK and experience many barriers to health care.[7] Women in these communities are also more likely to suffer regarding pregnancy, birth and access to perinatal services compared to women from non-ethnic minority groups.[8] GRT communities are known for having higher birth rates compared to non-GRT communities.[9] At the same time, a higher level of possible hazardous environmental conditions increases the potential for miscarriage and stillbirths, neonatal deaths and high rates of maternal death during pregnancy and after childbirth.[10]

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They are also 20 times more likely to experience the death of a child.[11] The unauthorised encampments where GRT women frequently live may be hazardous; for example, encampments next to canals risk waterborne contamination, rubbish tips may have rat infestations and waste ground can have an increased chance of fly-tipping. Moreover, there is often a lack of amenities such as clean water and cleaning and toilet facilities, as well as a higher risk of injury and illness in children compared to any other group.[12] It is estimated that '3000 families living roadside have limited or no access to basic water and sanitation.'[13]

**Why is it harder for GRT women and their community to access health services?**

GRT communities are rarely shown in a positive light by the media, local authorities and the government. They regularly experience harassment, direct and indirect discrimination and racism. This is a result of negative and incorrect stereotypes being systematically delivered via many different outlets. Many of the entrenched cultural prejudices go unchallenged and you are more likely to see racism against GRT communities on the front of newspapers and on social media. It is often seen as the last acceptable form of racism.[14]

Entrenched cultural prejudices not only have negative impacts on the GRT communities' carrying out their daily activities: they also impact their access to health care. Health reports continue to show stark inequalities in health problems and access to care.[15]

Indirect discrimination being carried out by the gatekeepers of health services and care increases the likelihood of GRT communities being unable to successfully gain access to them. Examples of indirect discrimination include GRT communities being wrongly denied the right to register with a new GP or dentist, due to not having ID or a permanent address, making it difficult to access or continue with regular health care due to evictions. Further, with no authorised short stay encampments and a lack of vital amenities such as clean water, toilets and cleaning facilities, GRT community members may have to cut their treatment short, miss appointments or give up treatment and care altogether.

**How do cultural differences affect the experiences of prenatal and postnatal GRT women?**

There are still conflicted ideals around women's bodies and how women should behave within the community, with female bodies needing to be covered up, especially around the opposite sex. Within the Roma community, the fear of being 'contaminated' by the female body, which leads to 'Marime,'[16] is still enforced, and discussing menstruation, pregnancy and birth can lead to dishonour,[17] though both males and females are capable of 'contaminating.'[18] However, the women of childbearing age have a stronger capacity to contaminate. As such, aprons are often worn from puberty in order to hide and avoid the shame of bodily functions and female clothes, especially female underwear, which cannot be washed with male clothes and washing cloths and towels due to contamination.[19]

During pregnancy for Roma communities, the pregnancy must be announced and then not discussed thereafter. The pregnant women will now be 'impure' and now must be isolated from the community if possible and looked after only by women. There is often shame attached to pregnancy. Women will no longer be allowed to carry out domestic duties such as cooking and cleaning due to being 'Marime' and will be until the baptism of the child or after 6 weeks. This is due to the 'contamination' which 'Marime' women can cause to food and water.[20]

Research conducted by Edden et al[21] found that much of the research around 'Marime' was correct, yet outdated, with only extremely traditional families carrying out all the traditions and rituals to avoid 'Marime.' Further many of their participants varied in how they carried out their traditions and rituals. This can also vary from country to country.

Cultural practices in the GRT community are important and therefore need to be understood. Many GRT women will not use the toilet facilities within their trailers as it is seen as unhygienic. They will also often opt for cooking outside their trailer and many authorised encampments will have separate lodgings for cooking and cleaning tasks. Furthermore, such traditions in Romany culture mean that there are strict rules around cleaning kitchen items, which are cleaned in a ritualistic manner in order to avoid becoming 'Marime.'

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Women may often prefer to use public toilets, for instance at petrol stations, and during pregnancy, they may drink less if they don't have close or easy access to these facilities. Research[22] found one woman being hospitalised for dehydration and being released from the hospital at 2 am once deemed fit enough. Local councils can authorise portaloos for women who are in the third trimester of pregnancy. However, many are denied this due to issues with accessing unauthorised encampments and thanks to evictions, portaloos are then not delivered to the new encampments.[23]

Many women may be living on unauthorised encampments whilst pregnant and experiencing frequent evictions by police using powers of eviction under Section 61 of the Criminal Justice Act.[24] Research[25] has found that some pregnant

women faced 3 evictions in the space of 2 weeks. Further, the evictions can cause stress and uncertainty, especially around being able to encamp somewhere close to a hospital. One woman expressed how she was due a visit from the midwife on the day of her eviction and the police would not allow her to wait.[26]

Even if GRT women have regular access to midwives, there may be further problems due to the midwife's lack of cultural and social understanding. Lack of training for midwives working with the GRT communities can lead to many GRT women expressing concerns about being treated differently by midwives.[27] GRT women often find their midwives cannot visit their encampments, as they cannot access them because of their rural location. Further, many midwives will overwhelm them with information and health literature when many cannot read or write.[28]

Frequently, evicted pregnant women express concerns about information-sharing from one hospital to the next. Many women will carry their hospital notes with them, as they have often found on arrival that the hospital has not received their notes or that vital information is missing.[29]

Support after the birth may be equally difficult to access. Further, if offered it will likely be declined.[30] GRT families are normally large, with some women having up to 10 children and parenting advice being passed down from generation to generation. GRT women take pride in being confident mothers and may not feel that they need further advice from health visitors.

English, Welsh, Scottish and Irish Travellers are very unlikely to take up breastfeeding.[31] Numbers are extremely low, with a study finding 3% taking it up for the first 6 weeks.[32] Breastfeeding is not seen as part of the culture and can be viewed as an 'immodest act,' whereas in Roma culture, breastfeeding is very much a part of the feeding process. However, breastfeeding needs to be done in complete privacy, which can be extremely hard to achieve in the community.[33]

The family are largely involved in the upbringing of the children, with many of the older siblings looking after their younger siblings whilst the mother cleans or runs errands. As such, many older siblings will see themselves as very experienced in raising children.[34] This is also the same in Roma communities, where everyone has a responsibility in raising the child.[35]

That is not to say that no English, Welsh, Scottish and Irish Travellers will take up breastfeeding given the correct support and advice. However, health visitors may have set views about the women they are supporting and may wrongly assume that they will not accept such advice. Therefore, they may be reluctant to explain the health benefits of breastfeeding and to offer support.[36]

Research found[37] that all the women they interviewed described a 'minimal service with little routine contact beyond the immediate post-natal period,' which also included support around breastfeeding. Many described how their health visitors were unable to understand the cultural and social differences.

It was further found that trusted relationships with health visitors that were built up over a period of time led to higher success rates in women taking up breastfeeding. Adequate social and cultural training for health professionals with predisposed views being challenged and changed will enable them to confidently support GRT women and build trusting relationships.[38]

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**How can UK health services, local services and local government improve access to health care for GRT women?**

Unfortunately, it is not enough for the UK to have an open-door policy to health care if it is in fact closed to those who do not know how to access it or who have had little or no previous relationship with it. Many GRT women will also be unaware of such services existing. Further, due to frequent evictions and lack of knowledge about new areas they move to, many will face further barriers. Those confident enough may try to access such service with little success. Friends, Families and Travellers[39] found that 'almost half of doctors and one third of dentists wrongfully refused to register Gypsies and Travellers if they had no fixed address or proof of identification.'

However, there are many services out there supporting GRT communities to gain access to health care. These are mainly GRT-based charities that are involved in policy changes, as well as in educating and training staff in health care settings. Many local authorities have carried out research on health inequalities and have recorded their failings. This has resulted in them taking steps to improve access with new funded projects to help reduce health inequalities; some local authorities, such as Bristol, now have dedicated GRT-trained health visitors and education leads.

In Cornwall, Travellerspace,[40] a charity supporting GRT communities in Cornwall and the South West, have set up a flagship midwifery project based at Teyuva Centre in St Day. The project includes newly appointed midwives and Travellerspace project staff.

Kernow Maternity Voices Partnership spoke to the community of the Wheal Jewel Traveller site about their experiences of maternity services. Feedback from the community was poor. This highlighted the need for a more 'bespoke, personalised, family centred approach' where their cultural needs could be met.[41] A partnership was formed that allowed for joint discussions, cultural training for midwives and even new logos for uniforms. There are now two culturally trained midwives who care for the women at the Wheal Jewel Traveller Site in St. Day, and they also work closely with other agencies to make sure the women's needs are met.

**Are GRT communities really protected under the Equality Act 2010 and can it be improved?**

GRT communities are protected under the Equality Act 2010 and public authorities should be thinking about how their policies protect GRT communities under this act. It is important for them to consider if their services or policies directly or indirectly exclude GRT communities from accessing services that are rightfully accessible to them. Friends, Families and Travellers[42] have created 'practical solutions' to help improve access to health services for both local authorities and GRT communities.

**Firstly,** local authorities and health services should understand the social and cultural needs of GRT communities. Not only can this improve the health outcomes of pregnant women within the community, but research has also found that this can lead to 'significant long-term cost savings for health and care services.'[43]

**Secondly**, they should be equipped to support pregnant GRT women. Has there been basic training for health staff to understand that members of GRT communities do not need ID or an address to register at a GP surgery or a dentist and should therefore not be turned away? Are they aware of trusted organisations who act as a 'care of' address? Are they aware of low-level literacy skills among these communities and can they offer discreet help with filling in forms and producing accessible health literature?

**Thirdly**, midwives and health advisors should be empowered to work across organisational lines. For example, do they seek advice from charities supporting GRT communities? Can they travel across geographic boundaries to deliver care to women who have been evicted? If not, can midwives contact midwives from other areas for them to continue the care they were once providing?

These practical solutions are not radical or difficult to implement; local authorities do not need to be examined on how to practically apply them. Large research reports being carried out by town and city councils will not be enough to end the disparities in the health care being received by GRT communities if basic training on social and cultural differences is not delivered at local levels or if such reports go unread. If cultural and social differences are ignored in local health settings, the disparities in the delivery of health care will continue, leaving GRT communities vulnerable and excluded from health care that they are rightfully entitled to.

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Article

# Birth and family traditions in Fiji

*by Siteri Tui Kurewaka; compiled by Luisa Izzi*

*Siteri dressed in traditional Fijian attire, wearing the Masi (printed bark-tree cloth) and the Tabua (whale's tooth).*

## Introductory note from the Editor

Siteri is a proud Fijian living in Scotland. She has three children, who were born in England, Germany and Scotland. Her husband, also from Fiji, serves in the British Armed Forces, and this is the reason why they moved from Fiji, first to Germany and then to Scotland.

There is a community of thousands of Fijians in the UK. Usually, there is a "Fiji Day Gathering" in October at the same time as the Fijian Independence Day, where Fijians from all over the UK gather with lots of other guests, coming to taste the food, experience the culture, see the dancing. Last year, there was supposed to be a celebration in the Highlands because there are several regiments with members of the Fijian community there: the Black Watch at Fort George, and more in Kinloss and Elgin.

I have never met Siteri in person, but we are both part of a local bilingual families group and we have some friends in common. When researching the theme for this issue of the AIMS Journal, I remembered this lovely lady from such a distant and different part of the world living in this small, rural area of Scotland, and I thought it would be wonderful to have a conversation with her about something as special as pregnancy and birth and the traditions of her family and her culture. Our conversation was emotional at times, but it was also joyous in how she shared special aspects of her culture, creating opportunities for our readers to learn about a place of which they probably have very little knowledge. **This piece is the result of our conversation.**

**Luisa:** Food is an important part of any culture. Is there anything special about food in Fiji that relates to being pregnant or being a mother?

**Siteri:** There is no particular food that you need to eat, it is just the same advice that the midwives would give us, to eat healthy, balanced meals. We are so fortunate in Fiji, we've got lots of greenery around us and processed food is limited, so there's lots of crops and fresh vegetables. Organic living is a must! Our grandmothers advise us to eat healthy food, lots of greens, that is basically it. There is no particular food that you need to stop eating or not eat, even seafood, I love my

seafood! Coming from the Pacific, we love fish and prawns. When I was 5 months pregnant with my youngest child, I had a talk (with the midwife?) because I saw these pamphlets that said you are not allowed to eat shellfish, so I asked and I was quite curious about that, and I thought it was quite unfortunate for me, I love to eat prawns, I love my crabs! But then, well, that was it, I was not able to eat seafood and fresh fish. If I was in Fiji, you would not be limited in anything, you are allowed to eat anything, as long as it's fresh and healthy, that's it.

**Luisa:** And is there any tradition or any words, or anything that family would do for you when you're pregnant? When you think about a woman in Fiji who is expecting a baby or has just had a baby, is there anything in particular that comes to mind that would happen in Fiji or that family would do?

**Siteri:** The birth of a baby in Fiji is a big thing. It's all the family, nuclear family and extended family. I am trying to compare both worlds, Fiji and here, and I miss home, I miss getting pampered. Back home you have a big feast, the men go out to sea to go fishing and they get really fresh fish for you in a bundle, root-crops are harvested and then they all will make a feast. There is something we call "earth-oven food", where you dig up the ground and then you roast pork or chicken, it's a special meal. We have a traditional mat called *Ibe*. Before the baby is born, the grandmothers will be weaving the mats, knitting nice pillows, getting ready with all the special things. The mum is not allowed to do anything, she is like a queen! She sits down, everyone makes sure that she is not tired, her legs get massaged. Mothers are treated in a special and delicate manner. When the baby is born, your grandmother, your mum, from both sides of the family, they all go to the hospital, there's a whole lot of people there with the mother, not only your husband! That is allowed in Fiji.

**Before the baby is born... [the] mum is not allowed to do anything, she is like a queen! She sits down, everyone makes sure that she is not tired, her legs get massaged. Mothers are treated in a special and delicate manner.**

Once the baby is born, even before mum holds the baby, we use a special *Masi*, a type of cloth made from the bark-tree which is printed and is part of our heritage. We are well known for using *Masi* on occasions like marriages or deaths, or any special events, or the birth of a baby! When the nurse gets the baby out, they're going to clean the baby and then, before he's been given back to the mum, the baby is wrapped in the *Masi*. All the family is there, wrapping the *Masi* over the clothes, it's a special gift, and then they will all hold the baby and pass the baby around, it's a very special occasion! And a happy occasion as well, because of the birth of a new baby.

After that, the mum gets better in the hospital, maybe for a few days, and then they will all go home together. Once they're home, the mum is not allowed to sit down and eat her food, because she could still be in pain, she's not deemed ready to sit properly at a table and eat. She's to lie down on the pillows and then it's the grandmothers who feed her. The mother only feeds her baby. The bathing of the baby, or when the baby cries, singing lullabies, all the grandmothers do that for four nights, called *Bogi Va* (four nights).

**It is also very important that we don't lose the umbilical cord: ...it's very important to us because that umbilical cord will be planted!**

It is also very important that we don't lose the umbilical cord: sometimes it goes missing in the hospital, but it's very important to us because that umbilical cord will be planted! So the grandmothers will be carrying the baby, singing chants, Fijian lullabies, and once it falls off and the baby is strong enough, they will give a big scream and they will be so happy! They will wrap the umbilical cord in a piece of *Masi* and they will allocate a special day for the ceremony. When I was born – I am the eldest in my family – my umbilical cord was planted under an orange tree! So that tree is my age. Any plant that the parents would love to have for their child can be chosen. Unfortunately, I lost my son's umbilical cord back in Germany, but I sent my daughter's back home, and for my youngest son I wasn't able to send it yet because of the Coronavirus!

It is our belief that if the umbilical cord is not planted, the children will grow up to be very cheeky and very naughty, not

stable in life. So that umbilical cord represents the fact that the children are strong, rooted, solid and stable.

**Luisa:** That is wonderful, it's making me emotional! No wonder these kinds of memories are making you emotional, too! This is obviously a way in which you kept these cultural traditions alive for your children, even if they were not born in Fiji.

So, your first child was born in Germany?

**Siteri:** No, my first child was born in England. We were living in Germany at the time, but my husband was deployed to Afghanistan, and I was alone, new to a foreign country and pregnant. There were other Fijian families around, but I wanted my family close. My brother lives in England – he used to be in the Army as well – so I was able to travel to the UK via a special route provided by the Army. I travelled when I was 5 months pregnant, and once there I tried to get registered with a midwife and bring my stuff across. We knew we were going to have a girl, and I really wanted my mum around. I had to keep telling myself, "You need to be strong. You're in a foreign country, but you chose to come here". So I tried to adapt and to go with the flow; it was no use trying to think back to those special moments.

One day, I came back from the hospital where I had gone for a check-up, and l had a call from Afghanistan; my husband had been shot. I sat down, I was crying; my brother and my sister-in-law ran up and I just handed the phone to them. It was the Sergeant Major, one of my husband's bosses. The Americans had taken him to their base to get treated. Little did they know that I was 8 months pregnant! And my husband was lying down with his injuries and was trying to tell his bosses, "Please, don't tell my wife! I need to speak to my wife!" It was a miscommunication at that point. I had high blood pressure, I was shaking, I was nervous, my mind was just completely racing. I was shattered, really, out of control. Luckily the nurse came in to check the baby, and baby was fine! My daughter was a happy, bubbly baby, everything with her was just fine; it was me, I needed to be cared for.

They flew my husband to Queen Elizabeth's Hospital in Birmingham, where he stayed for two weeks, and I was able to go and stay close to him for those two weeks. As I walked into the ICU, all the nurses realized that I was heavily pregnant, they were so shocked! And the Colonel was so terribly sorry that they didn't know I was pregnant, as they could have delayed the message. They did apologize. I always think of that, I really had a hard time. It took my husband some time to recover.

With my daughter, I had planned for a water birth at Salisbury Hospital, everything was decided, but I was rushed there in an ambulance in the morning and I was told by a nurse that the pool was on maintenance, and I thought, "Really? I had planned this with the doctors and the nurses, why is this happening now? Why didn't anyone tell me?" My husband was with me and he tried to comfort me, but I was very stressed and quite worried, really. My water broke back at the house and there was meconium in it, which is why it was an emergency. I never thought I would end up with a c-section, I never planned for it, but things happen and they kept telling me I would be fine. Even my dad called from Fiji to talk to me and help me make a decision! So I agreed, and my daughter was born at 10pm. My second child was also born by emergency c-section and my youngest was born by planned c-section.

**Luisa:** When you were talking about all those beautiful traditions in Fiji for the birth of a baby, did you ever take part in any of those ceremonies when you were still living in Fiji?

**Siteri:** No. Those traditions belong mostly to our aunties and grandmothers, to the older generations. I could maybe have helped to look after the little ones, but I wasn't really taking part. But we know what's important, and I have seen it as well. Actually, my brother's wife, she gave birth when we were in Fiji and I was twenty-something, and I took part as well, I was in the kitchen, helping out with the cooking! We were at home, so my sister-in-law's family, her mum, her auntie and her dad, came over, both sets of grandparents and great-aunts from our side. They were all there, so we had the event at home. My nephew was the first grandson, so it was really very special.

**Luisa:** So, you participated as a member of the extended family, but because you were not the right age or the right generation, you were not one of the people performing the ceremony.

Your first child was born in England, and then you went back to Germany and you had your second child there?

**Siteri:** Yes. When I came back from the hospital (after

having my second baby), I was really depressed. Straight after the birth of my son, my husband was deployed again. I tried to ask him if they could postpone it, because I had just had a baby, but he had to go, it's the way it is with his work. So I had to step up and do things that – had I been back in Fiji – I would not have had to do, like grocery shopping and cooking. I remember pushing the buggy up to our flat on the fourth floor, with the groceries and the baby, all the time crying to my mum on the phone, telling her that I missed home and I wished I was back at home. It was a really hard time and I had to adapt.

And then in 2015, before we came to Scotland, we travelled to Fiji, and that was the first time we took our two older kids to Fiji. On this occasion, we had another special ceremony: it's called the *Kaumatanigone* and it's the first time that they meet their grandparents, visit their native land, and see family. A big traditional feast was prepared. Once we arrived at the airport, I couldn't go to my family: I needed to go to my in-laws first for a few days. A very special element in this ceremony is a whale's tooth, a *Tabua*. This is a very important thing, a prized possession in any Fijian family: if you don't have money, but you have a whale's tooth, then you are considered a rich person, rich in your heritage. The families gather all these special things, the food and the mats and the whale's tooth, maybe the men will go fishing, and there is also a special crop called Dalo which is gathered in bundles. We all got together with all the things we gathered and then we presented our children – my daughter's name is Hannah and she was 5 and a half at the time, and my son's name is Sebastian Jr and he was 3 and a half – to my husband's family. He is from the coastal side of Fiji, while I live inland, so we then all travelled to my village, where my family had also prepared a big feast with all the traditional elements. They were all waiting for us. Once we got out of the car, the children were not supposed to step on the ground, so all the aunties came and carried the kids, all wrapped in fine fabrics, and presented them to my parents and grandparents. The children were each wearing a *Tabua*, a whale's tooth, and my father took that off and gave them a new one; it's an exchange, a passage.

Siteri and her children during the *Kaumatanigone*. You can see the *Ibe* (traditional woven mats) and the bales of fine fabric and *Masi* (traditional printed bark-tree cloth).

My children were very confused! My son was crying, probably because of all these people carrying him and the fact that he was wrapped in all the fabric, while my daughter was just shy, wondering where all these people had come from, who they were, and hiding in my dad's shirt. When we were sitting under the *Vatuniloa* (Fijian tent), all these people were staring at the children: it's bad manners here! But my family, they were so happy and so eager to look at them. And then it was official, my kids could come home to my family. At that point, my in-laws could go back to their house and I could stay with my family, because we had performed this rite of passage. If I hadn't done that and I had decided to go straight to my family from the airport, I would have been considered very rude, and I would have brought shame on my family. I enjoyed taking part in the *Kaumatanigone*, it is part of my heritage, and also how we show affection and care for each other.

**A very special element in this ceremony is a whale's tooth, a *Tabua*. This is a very important thing, a prized possession in any Fijian family: if you don't have money, but you have a whale's tooth, then you are considered a rich person, rich in your heritage.**

Siteri and her son Sebastian Jr during the *Kaumatanigone*. He is holding a *Tabua* in the form of a garland is all wrapped up in fine Masi. This picture was taken before Siteri's sisters came and took him to be presented to my Dad and Grand-aunt or Grandmother (whoever is the most senior in the family are the ones that the children will be presented to). Then they took off all the traditional attire that he was wearing and in return dressed him up in a similar fashion but from their side of the family.

My mum had actually met my children before; she came to Germany when I had my son, to provide support. She arrived the day after he was born and stayed for three months: it was the sweetest three months ever! I got treated to lovely food, my mum's cooking, getting good massages as well, she taught me how to bathe the baby, and all that. The fact that my mum was there with me made my experience so much better than the first time.

My mum was around when I was pregnant with my youngest son as well, but she couldn't cope with the Scottish weather and so she decided to go back to Fiji at the beginning of January 2020 and was planning to come back to Scotland in the summer. I gave birth a few weeks after she left, and then of course Covid and the lockdown happened. My mum actually thought she'd made a good decision because she wouldn't have been able to cope with the weather and lockdown in Scotland! And my third birth was a really good birth because I had planned it and everything just happened at the right time.

When I had my boy in Germany, the big barrier was the language: I could only use gestures or use my phone and Google Translate. When they took me to the theatre, I thought the injection they had given me had not made me numb enough, so I gave a terrible scream, and they gave me a different shot and I felt really woozy and dizzy. I couldn't have any skin-to-skin with my two older children, because after birth I had to go to a separate ward to be checked until the medications were out of my system, so my husband was the lucky one! I was pleased with my last birth: I had a spinal anaesthesia so I was awake, I opted to listen to classical music, my husband was there, I could see everything around me and they explained things to me, everything went according to plan. The midwives were lovely, they understood my culture as well. In Fiji, after a baby is born, we believe the mum needs to eat nutritious food, fish and meat, proteins to help with breastfeeding, and when I saw the food in the hospital, the sandwiches, oh my! There was this lovely midwife and she was very interested in where I was from, my culture and what I loved eating, and when I told her that my husband was going to cook and bring me a pot of fish from home, she asked me if she could try it as well! So I shared it with her and she loved it, red snapper in coconut milk (unfortunately there's no coconut trees in Scotland, so we had to make do with tins from Aldi)! That in itself made me feel so proud, I felt noticed not just as a mum, but they saw me as a unique person, and I got to share my culture as well. It was really special, it was such a small thing, but it made a big difference to me. The fact that I was breastfeeding as well was really positive. I breastfed all my three children, I am a big believer in breastfeeding, and I promote it on my Instagram as well, I have always enjoyed it!

We don't do baby showers in Fiji, but after the baby is born and the mother goes home there is a time called *Roqoroqo*. We don't receive visits straight away; people wait for the mum to be strong enough, maybe three weeks or a month. Some people may experience feelings of abandonment or separation, but friends and family know that you are there, they are just giving some time for the

mum to heal and rest, and then when they finally come it is another celebration! They will bring food and gifts and the *Masi* as well, the bark-tree cloth. We always present the *Masi* to friends and family, or receive it as a gift. And when visitors hold the baby for the first time, they will first wrap them in the bark cloth.

**Luisa:** One last question. You mentioned that in Germany you had some issues with the language, while in Scotland you felt a lot more confident and appreciated and seen as a unique person with your own traditions and culture. Is there anything else that happened when you had your babies that you think had to do with where you came from? Is there anything in the way that you were treated or the way in which they gave you information that made you feel different, or made you think that the reason why that was happening was that you were different or "foreign"?

**Siteri:** Right, I get your question. Not at all. I remember when my mum came (to Germany) and I was still in hospital after my c-section, I happened to have this midwife, an older German lady, and I remember that – maybe because of her age or mindset – she seemed so curious about me and wanted to know more about me. I had to introduce my mum to her and I said, "Mama", and I tried to explain that she had come from Fiji, very far away, and I was miming and using gestures, and all the time she was nodding and seemed very touched. She went to my mum and kept patting her on the back, and she had tears in her eyes. I wondered if maybe she was a mum herself and she was thinking about her own daughter. It was a special feeling. Even though we didn't speak the same language, the midwife could really relate to us, she could see me and my mum and our relationship. Everything became understandable, even though we couldn't technically understand each other.

At times I felt reluctant because of the colour of my skin, or concerned because I felt new and worried I couldn't understand the questions or the language, but I never felt the need to explain myself, and I always managed to establish a connection with people.

Article

# Where is the Village?

*by Beth Whitehead*

Birth is one of the most universal human experiences. Each birth is significant to the birthing mother and family. Yet in the Western world, modern maternity services appear to have managed to turn most births into crises where women and sometimes babies are coming out with some form of injury, physical, psychological or both. I remember when I had my first baby, I was seen by different midwives and obstetricians throughout my pregnancy. Each time, I had to explain my personal history and birthing preferences. Not all of them listened or respected that the decision belonged to the birthing woman, me. I felt that the service was inconsistent and inefficient.

**Birth**

At the birth at the hospital, I was handled by midwives that I had never met and they had no interest in my birthing decisions. The environment was hostile with harsh lighting. The midwives were stern and refused to listen. They were exercising protocols and treated me like a piece of meat going along a conveyor belt on an assembly line, being timed and squeezed into their processes. It was not surprising that in an environment where my birthing physiology and my humanity were not supported, I ended up having a long labour resulting in perineal injuries. It was like being kicked in the ankle when I tried to run. What stood out was not just the lack

of kindness, care and compassion, but how the practices undermined my intellect and my body. I never thought healthcare workers could behave in the way they did. It was a cultural shock.

## Early Postpartum

I grew up in Asia where the arrival of a baby was always a cause for celebration. We had family members and helpers around, usually older women, to assist with looking after the baby so the new mother could rest and recover. It is true that it takes a village to raise a child. However, in the UK, women are often left on the side like some discarded wounded animals with little or no support. I wanted to breastfeed my baby as it felt intuitive to me, but the staff at the hospital kept pushing me to give formula. The Trust advertised they had UNICEF Baby Friendly accreditation[1] but the reality of my experience was that there was no-one on site willing to offer breastfeeding support in those crucial early days. Sticking a bottle in the baby was pushed to me as the solution to everything, never mind what the individual mother or family wanted or the baby needed. I eventually gave in to the bullying and gave my baby some formula, but he just spat it out and cried. We later found out he was actually intolerant to dairy, so the cow's milk could have made him very sick. That is why an authoritarian approach without considering the individual's needs is harmful.

## Breastfeeding

Going home was good as I was not being harassed by the staff to keep giving formula anymore, but the lack of support for breastfeeding persisted. I tried the National Breastfeeding Helpline.[2] While it was comforting to talk to someone, what I really needed was in-person support as it would have been much more effective to be shown how to do something. Every mum and baby are different and now I know it is a partnership, how some adjustments in feeding positions, reading cues from the baby and encouragement can make significant differences to the nursing experience and length of feeding.

The knowledge of breastfeeding is usually passed on from older mothers to the younger ones in a communal environment but in the absence of such in the Western society, the help from breastfeeding counsellors is crucial. The low rate of breastfeeding in the UK is often cited as an issue when compared to the WHO recommendation,[3] but we only need to look at the environment women are in to understand how little support there is for their birth and postnatal journey.

The breastfeeding clinic at my local children's centre was open one morning a week for two hours. This support was the turning point for me and my baby to make nursing work for both of us. It was not just sad, but also infuriating when, over the years, the Conservative government cut the funding, the clinic was cancelled and, soon after, the children's centre was closed down too. The village vanished. Nurturing the next generation is one of the most valuable contributions that mothers make for their country. Yet it is undervalued, unappreciated and unsupported by the ones who reap the rewards of mothers' labour.

## Co-sleeping

When I was pregnant, my husband and I attended antenatal classes. We were told that co-sleeping with our baby would be dangerous and that we should put the baby to sleep in a cot. Being first-time parents, we tried to take on board all the advice, so we had a crib set up nicely for when our baby came home.

The first night after we brought our baby home, following hours of trying to put him to sleep in the crib and him crying inconsolably, it became clear that he did not want to sleep there. As soon as I laid him next to me on my bed with my arm stretched out away from the top of his head, he stopped crying and started rooting for my breasts to feed to sleep. It felt natural and soothing for both of us. We fell asleep together shortly after that. Somehow, my body always knew where he was and curved around him. I tried to see things from his perspective. After being inside me for months at a constant temperature, listening to my heartbeat, being outside, breathing, feeling different temperatures and textures must have been a strange, perhaps even shocking experience. Being close to me, feeling my warmth, my smell, and listening to my heartbeat again must have felt incredibly familiar, comforting and safe for him.

Bedsharing felt right for us. It brought back memories of me co-sleeping with my parents until I was about 4 years old. Waking up and knowing my parents were nearby made

1 www.unicef.org.uk/babyfriendly

2 www.nationalbreastfeedinghelpline.org.uk 0300 100 0212

3 www.who.int/health-topics/breastfeeding#tab=tab_1

me feel safe. The game-changer was once my baby and I worked out how to breastfeed lying down. It made me feel less achy. No-one told me how physically demanding looking after a newborn would be. In paintings and films, they almost always show how babies are fed using cradle hold with all the weight on the mother's arms. The reality for me was that it never felt natural nor comfortable. In fact, it gave me terrible back pain. Feeding lying down or with the baby from the side ('rugby hold') or with him straddling on my leg ('tiger in the tree') were the most comfortable positions for both of us. I guess aesthetically, they do not look as tidy, but nature is not meant to be neat. We all come in different shapes and sizes, hence no one size fits all, but we experiment and find ways that work for us. That is why flexible and kind attitudes and environments are important in supporting mothers in nurturing their babies.

## Postnatal Recovery

In an emergency on a flight, you must put the oxygen mask on yourself before you assist others. It is the same with postnatal recovery for mothers, except we live in a society where it is expected that the needs of others, e.g. the wider family or older children, are above a woman's own. It is completely cultural and irrational. There really is no need to sacrifice a new mother's well-being when it is a time for her to rest and recover. Looking at other cultural practices will shed some light on different ways to support mothers at this delicate time.

In South Asian culture, older female relatives usually give the new mother massages to help her relax. They make her nutritious food and herbal drinks that are believed to encourage breast milk production. I find that in the Western world, people are incredibly critical, arguing that herbal drinks do not contribute to milk production, due to the lack of scientific evidence. However, I think it is the kindness, care and thoughtfulness that make new mothers feel supported and relaxed, so that the hormones in their bodies can respond more favourably in nurturing their babies. Looking at the chemical composition of the herbs is really missing the point of how humanity, care and healing work.

In Southeast Asia, new mothers usually spend the first month after giving birth in confinement, resting at home with their baby. This is seen as a critical time for the mother's long-term health. Family members or hired help take over the housework and bring her special postnatal food, often rich in collagen for repairing her body, containing nutrients believed to encourage breast milk production. These cultural practices acknowledge the fact that new mothers need rest and support for their postnatal recovery.

It is disturbing that practices that are natural, intuitive and helpful for mothering, such as physiological birth, postnatal recuperation and co-sleeping, are often shunned or discouraged in the UK. The time has come to reflect on how new mothers are supported or not supported in this country. What can the government and everyone else do to nurture these important life givers and carers? We need to bring back the village.

*Beth Whitehead is a writer on maternity and women's rights matters. She lives in Southeast England with her husband and children.*

## Recommended Reading

1 The AIMS Guide to Your Rights in Pregnancy & Birth by Emma Ashworth
2 The AIMS Guide to Resolution after Birth by Shane Ridley
3 Why Mothering Matters by Maddie McMahon
4 Why Breastfeeding Matters by Charlotte Young
5 The Fourth Trimester: A Postpartum Guide to Healing Your Body, Balancing Your Emotions and Restoring Your Vitality by Kimberly Ann Johnson
6 The Lullaby Trust has up-to-date evidence-based guidance on safe sleeping (includes co-sleeping) in the UK
www.lullabytrust.org.uk
7 Breastfeeding image courtesy of the Baby Sleep Information Source website www.basisonline.org.uk

Article

# A Deaf Mum's maternity experience

*by Martine Monksfield*

It was quite the shock when the sonographer told me I was expecting twins at my 12 week scan in January 2021. Married to a Deaf man, I have a 7 and 5 year old (hearing) at home already affectionately called GingerNut 1 and GingerNut 2, and the pregnancies with them both were tough on me with severe sickness and intrahepatic cholestasis of pregnancy (ICP), also known as obstetric cholestasis (OC)[1]. We always wanted more children but we were very conscious of the toll of pregnancy on me. The irony that the terrible pandemic and the restrictions that came with it meant we figured it was a good time to go for another. The flexibility of working from home would allow me the space to rest and recover as my role as an advisory Teacher of the Deaf involves local travel to several family homes, nurseries, schools and colleges.

I am very glad we did this as I knew I was pregnant in week 4 when I started throwing up on the school run with my older two. It deteriorated from there, to the point where I was diagnosed with hyperemesis gravidarum (HG).

In early January 2021, before the scan I went to my first booking appointment in tears, having been in a vicious cycle between my bed and the toilet for all of December 2020. Thank goodness for a new medication that was prescribed for me, a mixture of antihistamine and Vitamin B6, designed for severe sickness and vomiting in pregnancy, which has reduced my symptoms somewhat to a level where I can function more normally. My boss was incredibly understanding too when I returned from two-weeks sick leave in January while I recovered and adjusted to the medication, as it made me very drowsy initially.

Communication at the 12-week scan was smooth, despite the sonographer and his assistant wearing medical masks. The shock of twins meant I had several questions which were all answered. This was possible due to the use of a British Sign Language (BSL) interpreter, which I hadn't even requested as I had lost faith in the NHS to secure them for me from previous experiences. I'd request one, but none were ever booked. It was always claimed 'no one was available' – something many of my Deaf friends and I heard several times when we shared experiences. I do question whether this is standard practice for all Deaf Mums-to-be, as not every Deaf person uses British Sign Language. How did they know I used BSL?

Looking back, I think there was no system implemented to secure BSL interpreters and admin staff had no idea one was needed or did not know how to book one. I know from other Deaf people's experiences that this lack of BSL access rings true in other departments across the NHS[2]. One

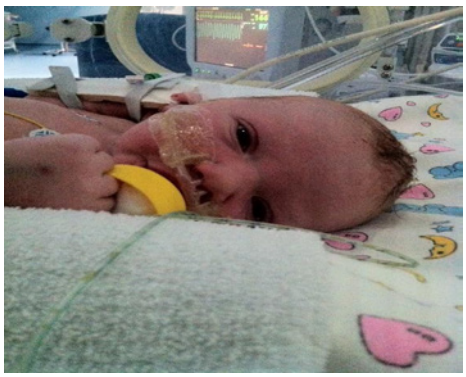
worrying example was when a daughter had to interpret when her father was receiving a terminal cancer diagnosis[3]. There is a real lack of funding for BSL access, lack of Deaf awareness and a very poor infrastructure. It seems to be a bit of a postcode lottery. I am fortunate to have speech and am able to voice for myself, but the input of spoken English to my ears is never a guarantee despite the advances in technology (cochlear implants, hearing aids, bone-anchored hearing aids, etc.), so the use of BSL interpreters in my life relieves me of that burden and ensures communication is smooth. It means I have more energy to listen when BSL interpreters are not available (not that I would want one attached to my hip anyway!). While the diversity of its staff is one of the strengths of the NHS, it can add to the challenge for Deaf parents, and there were times where **I struggled to follow/understand unfamiliar accents. It would take me a good 10 minutes to adjust, with lots of repetitions and some writing down of key words I couldn't understand despite 'hearing' them. This is one reason why continuity of carer, seeing the same midwife on every visit, would be really helpful to Deaf women.**

There were some positives in previous pregnancies; I was often texted with the results of my blood tests (especially for ICP) and also for appointment notifications and reminders (generic now for all appointments), which really helped, but there were the odd phone calls when I would run about looking for the nearest hearing person in case it was maternity needing to get hold of me. I didn't have a BSL interpreter during my first vaginal birth, nor for my c-section when I had my second baby, but as it went as well as could be with my Deaf husband for communication support, I just accepted early on that I would be going without.

Looking back, I wish I had had a BSL interpreter with my first pregnancy as it only transpired during my second pregnancy that I had had ICP with my first and that this was never communicated to me. I am certain there was an air of restricted communication with me because of my deafness and everything was very 'basic' in terms of what was relayed to me. This can be demoralising given I am a very capable independent Mum with a postgraduate education. I would have appreciated the written information, even printouts, but I suspect that this is time-consuming for them. It also would have meant I would have read it all and had questions, for which I would have needed a BSL interpreter. I am not sure they had the facilities to organise this then. Written information is not accessible to all Deaf mums as not everyone has a good level of literacy skills due to education not being accessible or because of language deprivation in the early years (signed or spoken).

I remember some midwives in the post labour ward after my first, asking how I was going to be alerted to a baby waking for a feed and if I had someone hearing at home with me. This was interesting, the fact they immediately assumed I needed a carer. I explained I had a baby monitor alarm which would vibrate my pager when the baby was crying. In the olden days without the use of assistive technologies I was regaled with stories of Deaf Mums attaching a string to their baby's wrist and to their own wrist to alert them when babies were crying at night (usually with arms akimbo!). With my first baby in the post labour ward, the pager would alert me to every other baby crying at night, not just my own. For this reason I came out of the hospital quite tired and relieved to be home. When I had my second, I asked for a private room for that reason, and thankfully there was space for me to have one. I think this needs to be standard for all Deaf Mums, ensuring they have the assistive technology to alert them to their crying baby.

It cannot be assumed that all Deaf Mums are even aware that this technology exists. There are no specialised health visitors for deaf mums. There used to be specialised deaf social workers, but this has gone now and deaf people are in the general sensory support team. My experience with them is that they don't know what technology is out there for deaf people. We have a Deaf Mummies and Friends group on Facebook where we share tips, advice and guidance for things like this[4]. The big issue at the moment is the discontinuation of video cameras with monitors that vibrate! Many parents are using two systems, one where there is an audio system with a vibrating pager, and a video camera with a monitor that doesn't vibrate. Not all deaf mums get information or access to this sort of assistive technology for a myriad of reasons linked to education.



GingerNut 1 born Jan 2015 by vaginal delivery, then in neo-natal care for 24 hours as a precaution, as his meconium was in my waters.

GingerNut 1 was 8lb 11oz. I remained in hospital with him for 5 days due to my liver function being abnormal (which we realised in the 2nd pregnancy was ICP/OC, but no professional communicated this to me at the time!)

GingerNut 2 born by c-section due to being breech and ICP/OC, needing to be delivered before 37 weeks. Born at 36 + 5, this one was 8lb!

I was very grateful that, for whatever reason, my experience as a Deaf woman had greatly improved since then. I have not had to request, check or worry if a BSL interpreter is going to be booked for all my maternity appointments, bar one, which was at the last minute for a scan and no one was available (I believed that this time!). They wanted me to wait until someone was available, but it was coming up to 50 minutes past my appointment time and I was starting to feel a little unwell (thanks HG!). In this instance, they were happy to remove their masks with social distancing in the room after the scan to go through the process and what they had seen. This massively removed the burden on me to ensure accessible communication during maternity appointments. My other Deaf friends who are also expecting a baby have reported the same – BSL interpreters are now being regularly booked for their maternity appointments.

My best friend, also Deaf and who has just had her 3rd baby, trained to be a midwife before stopping after her 2nd year for personal reasons. She found the interviewing process arduous and discriminating. My friend was told in no uncertain terms that she would have to be able to meet one of the components to pass – the Pinard test, where you listen to the baby's heartbeat.

Pinard


Sonic Aid

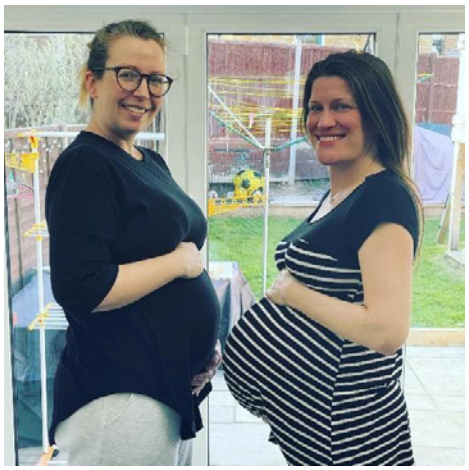
Apparently, this isn't actually commonly used anymore (not that she knew that at the time). She sought out ways to get round this, and discovered there was an amplified stethoscope you could order from America for those with

deafness in order to listen to heartbeats. The stress and pressure on her during the training process on this one component caused several sleepless nights with no support from senior midwives for reasonable adjustments. Other trainees and registered midwives (hearing) would also tell her they could barely hear the heartbeat on the Pinard. She found out that the Sonic Aid was used to listen to the baby's heartbeat and was very loud, so she was able to use this instead.

It seemed to her that the components set by the NMC (Nursing and Midwifery Council) did not consider any reasonable adjustments for trainee midwives with disabilities, and it was only through the support of other trainees and registered midwives who suggested reasonable adjustments that she was able to pass the Pinard test with a note to say she passed this with the Sonic Aid. To this day she remains perplexed as to why she was accepted on the course if the interviewers were very reserved about her passing this particular component during the interview. She was asked how she was going to communicate with mothers-to-be if they had her back turned to them. Fairly straightforward solution: ask them to look at her when they spoke, something Deaf people do daily. It was a real shame they didn't see the advantage of having a Deaf midwife in the profession, as not all mothers-to-be are hearing and Deaf people are more likely to know how to find solutions for communication as they are used to doing it their whole lives. This knowledge, skill and experience can be shared with the midwife profession which can only benefit the NHS in the long-term when learning how to communicate with a range of Deaf mothers; from those who use BSL to those who don't.

One thing that definitely needs improvement is the way in which Deaf Mums-to-be are contacted post birth – either by the midwife or health visitors to their homes. Often, visiting healthcare professionals don't know that the Mum-to-be is Deaf and make phone calls, which will frequently go unanswered if there is no hearing person nearby to take them. I know this because my best friend (mentioned above) recently gave birth and there were a few missed calls before the midwife just turned up at the door. Thankfully, we were at home!


The handover process between the labour ward/post-labour ward and the post-birth teams needs to ensure this information is included and that it is made obvious, and that midwives and health visitors know how to text and also how to book BSL interpreters for home visits should one be needed. I've been fortunate that in my area, my mother-in-law was a manager of the health visiting team, so she is always on the lookout for this information and knows how to text if mums are deaf and that she should book BSL interpreters for Deaf Mums in the area. She knows this because her son and her daughter-in-law are deaf, and if she isn't sure, she is able to ask us for advice. What about those who don't have this kind of network?



My best friend and me, me at 24 weeks and her at 39+5, in between her irregular contractions – she gave birth 6 hours later!

I've been fortunate to have a Sign Live account. Sign Live is a BSL video interpreting agency that I can use on my phone, anytime and anywhere. This is paid for through Access to Work for my job[5], but sometimes I will use it elsewhere where appropriate. I have a special phone number that looks

like a landline number but is actually connected to my mobile number .Anyone needing to speak to me to discuss something that can't be done over text message (where they would text my usual mobile number) is automatically connected to a BSL interpreter from Sign Live before being connected to me. I will answer the phone as it comes up as 'Sign Live' so I know immediately that someone is genuinely trying to get hold of me. If a typical number comes up on my mobile, I don't answer it because there are too many variables to ensure I can understand and follow a phone conversation; accents, background noise, clarity of speaker, unknown context, etc. Unfortunately, listening involves so much more than just 'hearing' for a Deaf person. Recently, maternity contacted me to talk about my Liver Function Test results as they have shown a high level of ALT (Alanine Transaminase) – 383 compared to the maximum of 35! They had to explain what I needed to do to start regular monitoring as we all suspect that this could be the onset of OC/ICP. SignLive will be especially useful if I have last-minute appointments with maternity and they cannot get hold of a BSL interpreter face-to-face. I suspect I will be using this sometimes[6].


Access to Work
Making work possible

After every baby is born, they undergo a newborn hearing screening test before going home (or they come back in for it). Some professionals need to be aware of the language they use with regard to this: many of my Deaf friends are often told, 'Congratulations, it's good/great news, they passed!', as if being Deaf is bad news. It's understandable to say this to hearing parents who have no experience of deafness and who would therefore find it worrying, but not all Deaf parents feel this way. We were fortunate in that we made it clear to the professional carrying out the newborn screening for our babies that we would not be upset at a referral and that we considered Deafness a cultural linguistic minority; moreover, even if the babies were hearing, they would be learning BSL anyway.

I am hoping all goes well with this twin pregnancy – there is definitely a sense from me that communication has improved this time around, but there's always room for more tweaking to make it work for all Deaf people entering maternity care. Wish me luck!

*Martine is a profoundly deaf advisory Teacher of the Deaf, uses a cochlear implant and is bilingual in British Sign Language and English.*

Twitter: @martinemonks

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4 Deaf Mummies & Friends UK Facebook group: www.facebook.com/groups/761751567214726/.

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6 SignLive: https://signlive.co.uk/.

Article

# Being in-between: An interview with an interpreter

*by Katharine Handel*

Katharine Handel

Zori Jeffries

As we know, AIMS's goal is to work towards better births for all through campaigning and sharing information, to protect human rights in childbirth, and to help women to know their rights, whatever birth they want and wherever they want it. Given the theme of our current issue, I wanted to consider how that might work for women who don't speak English as a native language, so I spoke to Zori Jeffries, a Bulgarian interpreter, to ask her about her experiences of supporting and advocating for Bulgarian women during pregnancy and birth.

Zori moved to England in 2010 and was inspired to become an interpreter because of her own experience of feeling frustrated with being unable to communicate in everyday situations and out of a desire to help those in a similar situation. Her husband is English and she has two children. She lives in Shropshire, where there is quite a large Bulgarian community, and has been working as an interpreter with Absolute Interpreting and Translations Ltd for four years. In her work, she covers many different types of hospital visits, but about 80% of her time is spent on maternity appointments, which is around 30 women a week on average, including all aspects of maternity care such as midwife appointments, scans, and labour. My conversation with her was fascinating and gave me a new appreciation of the crucial role of an interpreter as a mediator in what can sometimes be very stressful and difficult situations.

**KH: Hi, Zori, thanks so much for talking to me! How's your week going?**

**ZJ:** Well, it's very busy! Yesterday, I was busy until about 2 pm, and then I got a call that there was a lady in labour, so I ended up in the hospital all night until 7 o'clock this morning, and then I kept going with the rest of my appointments for the day.

**KH: Wow, that does sound busy! And it must be a challenge, because you don't know how long a maternity appointment is going to last in the way that you might with another appointment.**

**ZJ:** No, you never know. So they may book you for a labour for, say, 5 hours, but then you end up working for 24 hours, or some days there might be complications where they need to rush the lady to theatre, so it's very challenging.

**KH: So do you have to be on standby if you know you're going to be supporting a pregnant woman?**

**ZJ:** Yes, usually I'm with the women from their very first appointment up until the birth, so if I know that their due date is coming up, then I make myself available so that they can ring me at any time and I can go to the hospital.

**KH: What would happen if you were supporting a woman and she needed to go to hospital unexpectedly?**

**ZJ:** I make myself available all the time, but I also cover cancer and other types of surgeries, and if I'm in surgery, then I won't be able to do much. For example, if I'm in the hospital and a pregnant lady needs a last-minute appointment and I say 'my client is in surgery,' then I might run off quickly to the other side of the hospital and help. But it's not physically possible to see all the women; you just have to do the best you can in the circumstances.

**KH: And are the appointments conducted entirely in Bulgarian, or does it depend on the woman's level of English?**

**ZJ:** Usually, the appointment is conducted through me. Some of the women have very basic English and they prefer to speak as much as they can, but anything they are struggling to say, they say in Bulgarian. Sometimes they ask the doctor if they can practise their English when they come into the appointment and they speak as much as they are able to, and if they struggle, then I get involved.

**KH: And how do you think being there helps?**

**ZJ:** I think it helps because I speak Bulgarian and I'm a very calm person: even in very stressful situations, I try to remain calm. And because we share the same culture and the same language, the women feel more comfortable with me being there. It's very stressful to be in hospital and not speak the language at all.

**KH: You must get to know the women quite well, if you get to meet them from their first appointment all the way through? Do you ever feel protective of them?**

**ZJ:** Yes, you get to know them quite well. Obviously, I'm an interpreter and I can't make any personal relationships, because my job is basically to translate, it's not to make personal friendships. And that's a very tricky part because if you involve friendship, then you can't be impartial any more, so you need to make sure that you keep that professional part as well. It's natural to be, not a friend, but closer with somebody, but obviously you can't do that. It's a normal, natural feeling, to feel protective, but of course they're in better hands with the midwives and doctors. The best that I can do is to make sure that I translate and that way they've got the right support.

**KH: How does an appointment work? Where are you in the room when you are interpreting?**

**ZJ:** If it's a routine appointment, then I sit next to the woman. During labour, I also usually sit next to her, but I try to be next to her shoulder and head so that she won't feel uncomfortable or worry that I might see something. I try to make it comfortable for her so that she will be able to listen to me when I speak and so I won't be in the way. It's very traditional for Bulgarian men to not be at the birth; it's shocking for them if you ask them to be part of the process. The majority of Bulgarian men are scared and they don't want to be in the room, and many of the women are here without family members who can come with them to the hospital, so I am the support!

**KH: And at what point do you stop supporting the women? Do you stay until the baby is born, or do you also attend the health visitor and midwife appointments afterwards?**

**ZJ:** Once everything is ok with the baby, my job finishes. In cases where there are ongoing appointments, I keep going: for example, I work with a couple of families who have babies with Down syndrome and I attend their appointments for speech and language therapy, physiotherapy, all sorts of appointments.

**KH: So you might be seeing the same client for years and years, if you're supporting them with a long-term condition?**

**ZJ:** Yes, exactly.

**KH: What's your favourite part of your job?**

**ZJ:** Seeing the babies!

**KH: And how about the most challenging part?**

**ZJ:** For me, probably the most challenging thing is the differences between the typical Bulgarian culture and the culture here in England. Sometimes I have to stop the midwives or the doctors so that I can explain to the women why, for example, they ask so many questions here, because some of the questions are quite personal, and in Bulgaria that's not normal. The other thing that I find challenging is that most Bulgarian women prefer more natural things. For example, during their pregnancy, most of them will be vegan, and they'll be extremely healthy. They also don't believe in vaccines.

**KH: Oh, really?**

**ZJ:** Yes, I can say that 90% of pregnant Bulgarian women refuse vaccines and vitamin K, because they believe in their immune system and being healthy through healthy eating and activities. In Bulgaria, we prefer a more natural approach and don't necessarily take pills or injections if there is no need for it; if we're not ill, then we don't take

anything, and even if you're ill, you try to heal yourself more with natural stuff instead of with medications. So I have to explain to the midwife how typical Bulgarian women prefer to go through pregnancy, and that for them, offering vaccines all the time, for example, or telling them how to eat – though I'm not saying what is right or wrong, because it's not up to me – is not normal. I just try to smooth the conversations between the midwives and the pregnant woman.

**KH: And how do you approach that? That sounds like quite a tough situation.**

**ZJ:** Yes. The majority of the time, the frustration comes from the ladies: it comes from the fact that you see a different midwife at every appointment, so you get asked the same questions again. Of course the midwives will recommend these things, because they believe that they are something that will help the baby. So the challenging thing is that in every appointment the women will be pushed and reminded that they have to have it, and most of the women get very frustrated and they say, "It's my choice, I don't want to hear that any more," and then they are challenged again in the next appointment. In our culture, people are very direct, so if they have to answer the same question for a second, third, or fourth time, they start to get very agitated: you can see it in their body language, and they start to become more aggressive. And here in England, everyone is so calm, you might repeat yourself a thousand times and nobody minds. So I think that is a difference in the cultures, so I have to manage to be able to smooth that aggression.

**KH: How do those conversations normally resolve?**

**ZJ:** The doctors and midwives are very understanding and accept all sorts of cultures. As soon as I explain to the Bulgarian woman that this is how it is in England and to the doctors how it is in Bulgaria, then everything is usually fine.

**KH: How has your job changed during the pandemic? Were you still able to go to appointments in person?**

**ZJ:** Last year, when the pandemic started and we went into full lockdown, a lot of appointments were cancelled. And they were doing appointments over the phone, which is really difficult, because when you haven't got that visual contact and you're speaking another language, I think it's quite challenging, not for me, but for the medical staff and the patients. But I think everything is back to normal now. And I think the other thing that made a lot of women frustrated last year was that they weren't allowed to have partners during the birth. So I ended up having a lot of negativity on me, because usually that's what happens, because they only speak Bulgarian, and they can take all their frustration out in that language.

**KH: That must put you in a position of tremendous stress sometimes, being in the middle of these difficult conversations.**

**ZJ:** Yes. And sometimes, I have to be careful, because the doctors' and midwives' jobs are more stressful than mine. I mean, they're responsible for a person's life and a baby's life. So I try not to translate all of the bad things that have been said, because I don't want to put them under that extra pressure, because sometimes extra pressure can make you make mistakes. So if it's not important and somebody's been very nasty and it's only words, I will try to avoid saying it at that moment, and maybe when everything finishes I will tell the doctor or the midwife what has been said. And that's very important, I think as well, to think of the mental health of the doctors. Because you can see that they mean it: sometimes medical staff can ask questions just to be nice because they've been told to be nice, but I can see that all the midwives and doctors are not asking questions to be nice, because they've been told to be nice; you can see that it's because they really care. And speaking personally, when my children were born, I had a brilliant experience with the NHS, I can't say anything bad about it. Spending so many years working in the NHS and seeing different situations, I can say that they are absolutely brilliant.

**KH: I'm really pleased to hear that you had such a positive experience! Thank you so much for your time, Zori, it was lovely talking to you.**

**ZJ:** Thank you!

*Katharine Handel is an editor and researcher. She is one of the editors of the AIMS journal and is also one of the co-ordinators of The Motherkind Café, an Oxfordshire post-natal peer support group. She lives in Oxfordshire with her husband and son.*

Article

# Listening to the pregnant body

*by Emily Carson*

*Editor's note: The theme of this issue of the AIMS journal explores what it is like to give birth in the UK when the person's family or ethnic culture of origin, and their first language, is very different from that encountered throughout their maternity care experience.*

*In this article, Emily Carson introduces us to the idea that the body, knowing what it needs to feel safe, communicates this to us if we care to listen. Listening to the body is not the same as listening to the thoughts in our head; the body speaks a different language. It is an 'embodied' language and speaks to us through our feelings and senses. Emily refers to this as felt-sense communication. It is a language that has become a foreign one for many of us and one that, in our society, we are increasingly told not to trust. Emily explains why learning this language and learning to trust it is important and can be transformative. There are times in this article when you may need to stop and reflect, and occasional words that may be unfamiliar, but we feel pretty sure it will set your mind-body connection abuzz.*

Emily Carson

Our notion of health is shaped by the language we speak, the words we use to talk about the body, in addition to the cultural lenses through which we come to exist within our bodies. Language and culture greatly influence the way in which we experience menarche, the menstrual cycle, sensuality, sexuality, conception, pregnancy, birth, postpartum, and menopause. Culture affects whether these phases and experiences of life are pathologized, considered burdens or celebrated as expressive of our aliveness as rites of passage. The cultural stories passed on to us shape the way in which we inhabit our bodies and relate to pathogenic or salutogenic care.

As pregnant human-animals we are biologically wired to incentivise safety and connection. At this biological level, we determine safety and orientate to connection through the mind-body language of somatics, by 'listening to the body'. This language is one that we all know and converse in, every moment of every day, and yet it is a language we aren't taught and that we don't overtly include in how we approach care for those in pregnancy, birth and postpartum.

Our experience of pregnancy, giving birth and emerging into the postpartum time is defined by the culture we grow up in, shaped by biological imperatives. This article will look at how difficult it has become to listen to the body within the culture of the medicalised model of care in pregnancy and birth, while affirming and expanding on the vital role of embodiment and the language of the mammalian body during these times.

The above considerations will be made with embodiment as a central theme. The definition of 'embodiment' that feels most aligned with how I understand it is about being in conscious relationship with our bodies, in whatever way is supportive and accessible for each individual.

I invite you to pause and take a moment for a short embodiment practice, focusing on how you feel as you read.

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*Take a moment to notice your body.*
*Where is it?*
*If you were to close your eyes (you can if you'd like to), how do you know it is there?*
*How does it tell you? What sensory feedback lets you know? Take a few breaths to notice the body.*
*What does it feel like, just at this moment?*

*When you are ready, let your eyes guide your gaze away from this page and, in their own time, look around the space that you are in.*

*Your eyes may move slowly or quickly, let them find their pace. Allow your head and neck to move with them to enable them to fully scan the space you are in. Let your eyes wander high and low, in front of you, behind you. Let them land on a few objects in the space and take in the texture, colour and shape of that object.*

*Notice what happens to your breath as you look around. Notice what happens in your body. Are there any changes?*

*As your eyes naturally come to rest, let your attention come back to the body and notice how it feels again. Does it feel the same or different?*

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This exercise is a simple practice of landing and locating,[4] or orientating to the space that we currently exist in.

Why is this relevant? We are instinctive, primal beings who respond to and are impacted by our surroundings. Landing and locating ourselves is, very simply, a way in which we are able to track the potential for threat in our surroundings and thus assess and acknowledge safety.

This primal and instinctive assessment and acknowledgement of safety is a key aspect of supporting the physiology that enables an unimpeded birth process. When potential danger is detected, stress hormones increase and birth hormones decrease. This ensures that the baby is not born into a situation of danger. After birth, the body is also onally driven towards an increased cautiousness.[5]

The practice of landing and locating helps us to be aware of what is outside of ourselves whilst bringing awareness to embodiment. When we do this, we take an opportunity to listen to our body and notice if it really does feel safe. In gently attending to embodied awareness, we begin to recognise what we need with specificity, what we move towards, what we move away from and what we orientate towards in order to feel good.

As we enter into motherhood, cultivating concurrent internal/external awareness supports us as we navigate the throes of providing a stable base as an attachment figure for our baby, and as we emerge differently in the context of existing relationships.

## OUR SOCIAL NERVOUS SYSTEM

From the moment we are conceived, we exist in relation to the world and to others. We orientate to the world filtered through early primary attachments. We will therefore each have unique embodied experiences and a felt-sense understanding of intimacy, connection, isolation, loneliness, love, etc. Our experience of bonding is shaped not only biologically but also culturally.

Our social nervous system is shaped by our early relationships. This is where our orientation to and understanding of safety and danger begins. It isn't a conscious cognitive discernment, but an unconscious, somatically driven sense. This capacity for discernment is called neuroception.[6]

The process of neuroception is involuntary, innate and automatic. We are all neurocepting as we move through the world and assess it, and as we make our assessment, the sympathetic and parasympathetic branches of the autonomic nervous system respond.

When our system experiences 'danger' (the reality of danger will vary greatly from human to human), our sympathetic nervous system responds by producing stress hormones like adrenaline that send us into "flight or fight" mode. When we are presented with a life-threatening experience, our systems can move into a state of collapse or immobilisation, a freeze state. 'The more danger you're in, the more ancient your response.'[7] This means that the responses that arise in the face of grave danger arise within

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our reptilian brain (the primal part of our brain[8]).

In health, we can move from a safety response to a threat response and back to a safety response with ease. A healthy system can move between sympathetic and parasympathetic states.

The 'regulated' state, a state we are in when we feel safe, enables the parasympathetic nervous system to release beneficial hormones such as oxytocin and endorphins, which support all physiological processes like digestion, sleep and birth. The regulated state also fosters connection, supports learning, critical thinking and productivity, and helps life to be relaxing and enjoyable.[9]

When we are experiencing connection, tenderness or love (be it with another human or an animal), we are most likely feeling safe and are probably in a down-regulated, parasympathetic state: 'The Polyvagal Theory identifies co-regulation as a biological imperative: a need that must be met to sustain life. It is through reciprocal regulation of our autonomic states that we feel safe to move into connection and create trusting relationships'[10].

Just because safety and regulation hold many benefits, it does not mean that we should be avoiding "sympathetic nervous system activation". Our nervous system requires daily sympathetic activity to be healthy.

Often, we are told that feeling safe optimises and supports our birth experience. How we experience 'safety', however, is utterly dependent on how we orientate to relationships and to our surroundings (neuroception). It is also dependant on situation. Bringing a newborn into the world requires our animalistic instincts to be alert to threat because this leads us to seek out a birth environment that supports our system towards co-regulation, resonance and connection, one that is therefore safe for the baby.

Sometimes we can be driven to create a perception of safety by complying with caregivers and by going along with a procedure or intervention because we don't want to 'cause a fuss' or create dissonance. Whilst the nervous system isn't gendered, women on the whole tend towards fawning[11] and 'tend and befriend'[12] (sometimes known as 'freeze and appease') responses, which can lead us towards 'making things ok' when we actually don't feel ok in our body.

It is important to acknowledge here that there can be a clash between the safe prenatal and birth environments advocated to us by culture and society and the safety that our bodies are actually calling for.

## THE LANGUAGE AND CULTURE OF THE MEDICAL MODEL OF BIRTH

Activist and author Rachel Cargle notes that the nature of a society's gynaecological, pre and postpartum care 'reflects and reinforces the beliefs, values and power dynamics of the society at large' (2020).

The medicalised system of care for people in pregnancy, birth and postpartum focuses heavily on care that helps professionals rule out a medical problem or red flags (signs or symptoms that indicate the presence of serious pathology).

Whilst the medicalised model of obstetric care acknowledges 'shared decision-making' and 'informed decision-making', there is little offered to women and birthing people in the way of identifying and honouring their instinctive felt-sense experience. The medical culture surrounding birth carries out care steeped in litigious concern. When the cultural perception of safe birth is centred in medicalisation, we dissociate ourselves from the innate biological requirements of the body in the unfolding of birth.

**When the cultural perception of safe birth is centred in medicalisation, we dissociate ourselves from the innate biological requirements of the body in the unfolding of birth.**

We have a system of care (for which I am deeply grateful) that makes medical practitioners available to us when we are sick, but on the whole does little or nothing to support a mother or birthing person's ability to centre themselves and to connect with their instinctive experience. When we

8 Our amygdala is also termed the 'lizard brain' – the part of the brain that evolved from when we were reptiles.

9 Porges (2017).

10 Dana, D (2018). *The polyvagal theory in therapy: Engaging the rhythm of regulation*. New York: W.W. Norton & Co.

11 Verma, R et al. (2011). 'Gender differences in stress response: Role of developmental and biological determinants.' *Industrial Psychiatry Journal* 20,1:4–10. doi:10.4103/0972-6748.98407.

12 Levy, K et al. (2019), 'An attachment theoretical perspective on tend-and-befriend stress reactions.' *Evolutionary Psychological Science* 5, 426–439. https://doi.org/10.1007/s40806-019-00197-x.

consider a more health-centred care system, we would invite our care providers to hold the appropriate space for birth (both physically and philosophically) so that instinctive behaviours can surface and relationships of trust can be formed. As we explore this, it would be easy for us to enter into a narrative that polarises a pathogenic model of care and favours care that is driven by wellness.

**When we consider a more health-centred care system, we would invite our care providers to hold the appropriate space for birth (both physically and philosophically) so that instinctive behaviours can surface and relationships of trust can be formed.**

It would be easy for us to adopt the narrative that it is solely down to our maternity system to change, down to our obstetric healthcare practitioners to evolve and for the conventional care model to embrace a salutogenic emphasis in its care of the pregnant body. I do not deny that these are necessary aspects for the evolution of the current care model. However, in my view, requiring a system-focused change is overly simplistic.

In placing the responsibility on the care system alone to change, we are not realising our responsibility for moving towards a health-centred approach to maternity care, which is a collective embodied work that must also take into account how we 'inhabit the pregnant body'.

## INHABITING THE PREGNANT BODY

'Inhabiting the pregnant body' is a term used to describe the individual bodily experience of being a pregnant woman/person. It recognises that the physical experience of living inside a pregnant body is very different for each person. This is because the way in which we have become acquainted with and come to understand pregnancy is through a vast array of cultural stories portrayed through the media, community, and loved ones.

Did we see our mothers or sisters suffer in pregnancy? If so, we hold this experience in our bodies even if we rationalise it with our minds. Do we have a sense that we cannot allow pregnancy to overshadow our identity as working women? Do we hold a subconscious disgust in response to the womanliness of pregnancy or the change in physicality? Do we equate pregnancy and motherhood with becoming less sensual or sexual? Do we see pregnant women and people as goddesses that should be cared for, or as oversensitive and irritating? Our answers to these questions are shaped by the stories we have subconsciously archived on a cellular level about what it is to be pregnant, give birth and have a child. These intrinsic narratives strongly influence our orientation to care.

When someone enters into pregnancy, what is their role in their care? Whilst the maternity care system needs evolution, I also strongly hold that we need to change the way in which we exist with and within this system; to take onus for ensuring that care is tailored to our individual needs. When we are able to listen to our bodies and know what they need, then we can make decisions that support those needs and more confidently expect the system to treat us as agents of our own decision-making.

In pregnancy, birth and the postpartum time, it is not only right, but fundamental to the benefit of our body, mind, baby and bonding that we are treated in a way that not only supports but also encourages our innate instinct and autonomy. If in pregnancy we can move into and notice our embodied experience, we will be better able to advocate for this experience. From this place of self-understanding, we can discern which interactions are aligned with our needs and accept or decline accordingly.

Part of our collective pregnancy experience requires unlearning. Unlearning tendencies towards socially motivated compliance. Letting go of the familiar contours of our body and how it moves through the world and opening to an emergent physicality and somatic experience. How we nurture young women as they come into their bodies really matters because it has a direct influence over how they occupy their body in pregnancy.

In pregnancy, we are invited into wild and feral depths, where our soul, body, and psyche are expanding to encompass the ever-growing space within which another human is arriving. This unseen dance is where our system merges with the presence of new life. Where new life

presses up against our vital humanness and beckons us into an intricate, messy, carnal, visceral, beautiful, relational dyad. We are driven and primed by socialization. If we have been primed to be socially compliant, we can end up as the saboteur or inhibitor of our inner needs and desires. Pregnancy is a time that invites us to listen to our inner cues. To explore embodiment in a way that supports us to connect to instinct, to advocate for ourselves with clarity about what feels right for our body, baby and bonding.

Mothers and birthing people are holding the health of our emergent generations, tending the soil from which they are being raised. Women who are living in congruence with their agency, in an embodied way, are a significant part of weaving the communities, societies and cultures that our interconnectedness and planet depends on.

When we refer back to our felt-sense experience and name it, we are giving our authentic experience the space to be identified; we are acknowledging the experience we are having on a tissue or feeling level and saying, 'body, I hear you.'

As we allow ourselves to orientate to our body in the context of the space we are in and allow it to respond, we are loosening the ties of historical and cultural narrative, playing with breaking the bounds of story and existing with our truthful present moment experience.

*Emily is an integrative somatic practitioner, birth story listener, somatic educator, NCT Home Birth Group facilitator and mother based in Oxford, UK. Emily works with women and people through life cycles and holds a specific interest in postpartum care, a time through which she supports women and birthing people in their healing and recovery after birth and finding their connection to vitality and pleasure.*

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Article

# Understanding Intrahepatic Cholestasis of Pregnancy (ICP): The power of women coming together

*by Jenny Chambers*

*In this article, Jenny introduces us to the work of the charity she founded thirty years ago, ICP Support, and illustrates the benefits of service users coming together to work on issues of common concern. With a shared goal of ensuring that all ICP babies are born safely, by improving the understanding of the physiology of intrahepatic cholestasis of pregnancy (ICP) across the maternity services and by improving the care of everyone affected by ICP, Jenny's account demonstrates the crucial importance of having 'experts by experience' at the table.*

In 1991, I was diagnosed with intrahepatic cholestasis of pregnancy (ICP). ICP affects around 5,500 women a year in the UK and it is the most common liver disease specific to pregnancy. Its main symptom is itching, which can be so severe that some women have reported feeling suicidal.[2] ICP is also associated with spontaneous preterm birth, fetal distress and, in severe cases, stillbirth. When I was told I had ICP, I soon realised that no women – and only the odd health professional – knew about the condition. Because my own diagnosis had taken several pregnancies to establish, I wanted to raise awareness so that all women knew that itching in pregnancy wasn't always something to be dismissed. My plan was to do this for a few years, after which I would be able to get back to a 'normal' life.

This year sees the 30th Anniversary of ICP Support[1], and I'm still very much involved. The information line I started in 1991 has developed into a registered charity of which I am now the CEO. I'm lucky enough to have been supported in making the transition from being a lay person with no medical background to working in research into ICP, and I am now a named author on numerous peer-reviewed academic papers on ICP. I am also the first author on several midwifery articles. I've given presentations on the condition at midwifery conferences and delivered lectures to midwifery students. I'm still involved because I discovered that scientific research takes far longer than I originally thought it would, and because not all health professionals have embraced learning about the condition, as I thought they would. It's been quite a rollercoaster of a journey.

But what I also discovered along the way was the sheer joy of being with other women who have had ICP. I've learned just how much can be achieved when we all come together and work towards a common goal. In the case of ICP, that goal has always been the safe arrival of babies, and over the years I have been humbled by what women have been prepared to do for research that will help to ensure that all ICP babies are born safely. From donating their blood, urine and faeces to donating their babies' cord blood and placenta (post birth), women have done so much.[3] Some of them have also taken part in studies that have involved them eating standardised meals and having nine blood samples collected over a 7-hour time period; agreed to have electrode tabs put on their abdomen so that researchers can get an overnight fetal ECG recording of their babies;[4] and donated samples of their white adipose tissue collected during their caesarean sections. Their willingness to do all these things has been quite outstanding.

Because of these women, we now have a risk threshold for stillbirth in ICP (3.44% when bile acids are >100 μmol/L) as established by Ovadia et al.[5] This means that the 90% of women whose bile acids remain under this level throughout pregnancy can not only be reassured about the safety of their babies, but can also not have early induction (which has typically happened at around 37 weeks for ICP) if they want to (and if they can cope with the intractable itch that so many women with ICP have to endure).

Because of these women, Dixon et al[6] were able to identify genetic changes associated with ICP (and there is further research on this due out soon), meaning that in time it may be possible for women who have had the disease to

undergo genetic testing to see what variants they may carry. It may also mean that their daughters can be tested to see if they too carry the markers and how this will affect their chances of developing ICP: in this case, forewarned is most definitely forearmed!

And because of these women, researchers now have a better understanding of the longer-term impact of ICP[7] for women, which includes an increased risk of developing a liver disease such as gallstones. We now realise that ICP is not just for pregnancy – it's for life.

But of course, none of this could have happened without researchers, and in the UK we are lucky that one such researcher, Professor Catherine Williamson, made ICP her research focus[8]. Catherine is the reason I was able to make the transition from lay person to working in research and she's a terrific example of how PPI (Patient and Public Involvement) can work[9] because she is committed to listening to women, which includes asking them to comment on the design and feasibility of studies. The ethos of ICP Support has always been that we are research-based, and I know (because they tell me) just how much women value being involved in supporting it; it is, after all, their condition! Our role as a charity is to be the conduit between women and the researchers, and we do this by posting surveys for them to complete (usually about new studies), by conducting polls, and by hosting focus groups. We also hold live 'meet the expert' Facebook sessions, which have proved very popular.

It's going to be an interesting 12 months as we look back and reflect on how much has changed with the diagnosis and management of what has turned out to be a very complex condition of pregnancy, but what I do know is that the research will continue, and that as it does, the women affected by ICP will be with us all the way.

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9 NHS Health Research Authority website, 'Public involvement': www.hra.nhs.uk/planning-and-improving-research/best-practice/public-involvement/.

Further information on ICP – www.icpsupport.org
Facebook group for health professionals – https://www.facebook.com/groups/ICPSupporthealthcareprofessionals
Facebook group for women – https://www.facebook.com/groups/icpsupport
Instagram – icpsupport

*Jenny Chambers is the founder of ICP Support, and was only diagnosed with ICP after suffering a second stillbirth.*

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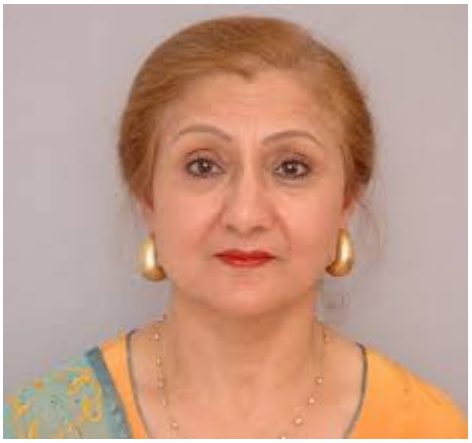
Interview

# An interview with Kuldip Bharj

*by AIMS Campaigns Team*

*Many different organisations and individuals play a part in the mission to improve UK maternity services for all, and midwifery educators play an important role in the maternity services improvement community. In this interview, the AIMS Campaigns Team talks to Kuldip Bharj, who has spent over 40 years of her career in midwifery, including roles in education, research and practice. Throughout her professional life, Kuldip has been dedicated to excellence in healthcare services, with a particular interest in the provision of services which are responsive to the needs of local communities. Kuldip was awarded an OBE in 2009 for her dedication and services to healthcare for communities in Leeds.*



**Thank you for agreeing to be interviewed by AIMS, Kuldip. To start, can you tell us more about what drives your interest in a well-functioning maternity service and what first attracted you to the idea of becoming a midwife?**

I have a keen interest in the social fabric of maternity services and the colourful threads of women, their babies and families, midwives, obstetricians and other healthcare professionals which weave through it, making beautiful designs.

I am deliberating as to what a well-functioning maternity service looks like. This would be a maternity service that is woman- and family-focused, culturally sensitive and appropriate to maintain health and reduce inequalities of health. A well-functioning maternity service is critical for the health and wellbeing of women, their babies and their families, as well as the clinicians who care for and support them.

At a very young age, I was attracted to caring, being inspired through early readings about the role of Florence Nightingale, I did not know about Mary Seacole then! It therefore came as no surprise that I entered nursing. During my nurse education, experience on the maternity wards, I was inspired to pursue a career in midwifery. Essentially, it was the privilege of being part of women's most sensitive journey that touched me most.

**You have had a distinguished career as a midwifery educator, latterly at the University of Leeds. Why did you move into teaching, and what for you are the essential qualities of a good midwifery lecturer?**

The best part of my professional life has been spent in midwifery education and I have very fond memories of it. Becoming a midwifery lecturer was not on my career radar. My talent in facilitating learning and teaching was identified in the early stages of my midwifery career, coupled with my ability to work with diverse communities and deliver culturally sensitive care. I was made responsible for delivering antenatal education classes for 'Asian' women – a role that I quickly extended by developing specialist classes for Asian women who had a limited ability to speak fluent English. I intuitively took on the role of interpreter and assisted many women and their families to overcome language barriers. I developed particular expertise in working with families who experienced disadvantage, for example women from poorer backgrounds, those from the Black, Asian and minority ethnic (BAME) communities and with teenage women.

In addition, I took particular interest in the education of learners on the wards, ensuring that they received high-quality clinical experience. My aptitude was recognised when I was seconded to work in the School of Midwifery. I demonstrated commitment to my own development through undertaking continuing professional/educational development programmes. In those days, such programmes were not easily accessible and support to undertake them was not readily available. I worked hard to convince senior managers to support me.

In terms of the essential qualities of a 'good' midwifery lecturer, I firmly believe that a midwifery educator is the orchestrator of creating a learning environment within which learners acquire the competence of 'becoming a midwife'; essentially, midwifery educators need the competence to 'be with the learner.' The learners must be seen as equal partners and should be treated with respect, kindness and compassion. Some of the qualities of good midwifery educators are open-mindedness, approachability and – importantly – the ability to develop constructive and trusting relationships. The midwifery educator should operate fairly and equitably, meeting the learners' individual needs. Over the years, the needs and expectations of midwifery learners have changed, bringing about a radical shift in pedagogical engagement, including student-centred inquiry and problem solving. Good midwifery educators need to be everything for the learners that a good midwife is to the women and their families.

**Since the late 1990s, AIMS has been concerned that the UK maternity services do not always work from a physiology-informed perspective. How did you seek to address this issue during your teaching career?**

I have seen a colossal transition in midwifery services over the past decades; they have altered beyond all recognition. Midwifery learners need to have a good understanding of physiology, as well as a good understanding of when and how medical intervention might be required, so that they are effectively prepared to work in complex settings. Many midwives' narratives highlight that they often come into conflict with organisational demands, due to their desire to provide physiology-informed care. Such conflicts do little for the delivery of woman-centred care and leave midwives dissatisfied, adversely affecting their confidence.

The philosophical underpinnings in my teaching and learning that address the above tension have been that midwives should work 'with women,' identifying women's personal and maternity needs; based on these, they develop care and management plans that suit the women and their families. There is a significant amount of evidence which confirms that whilst interventions in childbirth prevent harm and save lives, many women are subjected to unnecessary interventions which can be harmful too. Clearly, achieving a balance is important.

**In 2007, you completed your PhD studies, in which you explored the experiences and context of Pakistani Muslim women birthing in Northern England. Can you tell us a little about your key learning from that?**

Throughout my professional life, I have championed the equality agenda and have sought to bring the voices of all women and students, in particular those whose voices are seldom heard, from the margin to the centre. In my doctoral thesis[1], I set out to provide a platform for the voices of Pakistani Muslim women, promoting and enhancing their role as consumers of maternity services to shape future maternity services which respond effectively to their needs. Some of the key learning points highlighted by this study were:

a) Pakistani Muslim women do not have unique needs during childbirth; however, their needs continue to be unmet;

b) for Pakistani Muslim women, there were persistent service quality issues, despite many attempts to modernise maternity services; and

c) ethnicity is an important marker, in that experiences of women from a Pakistani Muslim background are worse than those of their 'White' counterparts.

Whilst some Pakistani Muslim women in this study communicated positive experiences during their encounters with maternity services, many narrated negative experiences. Many women in this study valued their relationships with the midwives. They saw midwives as being instrumental in their birth journeys, either making or marring their birth experience. When they did not secure professional support, they turned to 'Allah' during their uncharted birth journeys.

This work paved my way to working in strategic roles within the healthcare sector to shape and develop services to provide appropriate and relevant care to women and families from diverse backgrounds. I was instrumental in developing and ensuring that healthcare education prepared future healthcare practitioners to provide anti-discriminatory, culturally competent care. Furthermore, I engaged in research activities to generate knowledge in the field of ethnicity and diversity.

**In 2008, you co-authored a briefing paper for the Race Equality Foundation,** 'Addressing ethnic inequalities in maternity service experiences and outcomes: Responding to women's needs and preferences.'[2] **Thirteen years on, against a backdrop of continuing inequalities, the key messages in that paper seem remarkably familiar. What do you think have been the key barriers to the much-needed progress in this area and are you optimistic that the current focus on the very same issues will now lead to some resolution?**

I have been an advocate for equality in education and practice from as early as the 1970s, with publications in this field dating back to the 1990s. Disappointingly, despite numerous interventions the body of evidence persistently highlights that women from the BAME backgrounds experience poor clinical outcomes in terms of mortality and morbidity and that their satisfaction levels and maternity experiences are worse than those of their White counterparts.

The continuing ethnic disparities is without doubt disturbing; however, it is important to acknowledge that this is not due to inertia of the UK's NHS. One of the challenges for the delivery of equality in contemporary maternity services is that the UK is increasingly ethno-culturally and linguistically diverse. This creates opportunities and challenges for its economy and its social welfare system, including the delivery of maternity services.

The 'equality, diversity and inclusion' agenda is enormous and complex. When organisations attempt to address all the protected characteristics collectively, in my opinion, this dilutes the issues and potentially adversely affects the achievement of outcomes. Nevertheless, the agenda of 'Race' equality now appears to have been renewed; there is a focus on structural racism within the NHS, and there is a spotlight on maternity services through Parliamentary debates, the Birthrights inquiry[3] and campaigns such as Five X More[4].

A considerable synergy is needed between national commitments and the local provision of maternity services for women from the BAME backgrounds. Commissioners of maternity services need to play a central role in the translation of central government policies into service configurations and delivery of maternity services. Equality or inclusiveness are not add-ons; they **must** be embraced wholeheartedly with a paradigm shift in the culture of the organisation.

Midwives and other healthcare professionals need to work differently, reaching out to all women and providing the care they want. Midwives are the bedrock of maternity services and essentially contribute to improving outcomes for women and their babies. There are, of course, numerous challenges, such as how to promote midwifery as a career of choice and how to create a culture that encourages midwives to remain in the profession.

**There are, of course, numerous challenges, such as how to promote midwifery as a career of choice and how to create a culture that encourages midwives to remain in the profession.**

Evidence confirms that a significant number of midwives from the BAME backgrounds do not enjoy the same promotion prospects as their White colleagues and are not always treated with dignity and respect. Much is needed in this area: for organisations to have an open-door policy, reaching out to midwives from diverse backgrounds and improving promotional prospects for staff from the BAME backgrounds, including by looking at their own organisations to see who is at the upper and lower echelons. I have argued that for staff in the NHS and the higher education sector, it is not a glass ceiling but a concrete ceiling.

**In England this year, we are marking the fifth anniversary of the 2016 'Better Births' report. In your opinion, how much of an impact has that report had in driving maternity service improvement so far, and what parts of its agenda are you keen to see delivered still?**

Over 20 years ago, the 'Changing Childbirth' report was a watershed in maternity services, enshrining the concept of woman-centred care; humanised and responsive care including the three 'Cs': choice, continuity and control. Disappointingly, the aims of 'Changing Childbirth' were not fully achieved due to a number of constraints. Nonetheless,

what is exciting is that the publication of 'Better Births' has been underpinned by financial resources and people to deliver its aspirations. There have been several achievements within the Maternity Transformation Programme: for example, continuity of carer has been rolled out in some areas.

I would like to see this model of care rolled out for all women from the BAME backgrounds. I would like to see 'personalised care' become a reality for women, where they experience kind, compassionate and respectful care. For this to happen, it is essential that maternity services communicate effectively with those women who do not fluently speak and understand English. The evidence continues to highlight that the use of interpreters remains less than satisfactory, and if the ambitions of the 'Better Births' report are going to be realised then this issue needs to be a priority.

The campaigners for improved maternity services need to continue with their efforts to ensure that the maternity services are effectively resourced, so that they can provide and deliver safe and equitable services.

**What do you think is the biggest challenge faced in maternity service improvement work in the UK today?**

First of all, we must recognise that the British maternity services are the envy of many countries and are one of the safest at a global level. However, this does not mean that all is well. Maternity services have been under the limelight because of recent scandals where midwifery has been found to be seriously sub-standard. Investigation reports into maternity services persistently highlight the toxic organisational cultures which drive inertia, making organisations dysfunctional. This clearly must feature high on the improvement agenda.

One of the biggest challenges faced in maternity service improvement work is to look beyond 'hard' clinical outcomes such as perinatal mortality and consider the factors, including human factors, which propel effective working within organisations; namely, respectful relationships between clinical teams and women and the services.

The UK has some of the best evidence, policies and targets for maternity services: the challenge is to embed these into practice, so they become part of maternity services' fabric.

**AIMS celebrated its 60th birthday last year. Looking forward, how do you think AIMS might best focus our limited resources to help ensure improved maternity services for all?**

What an achievement reaching a prime age of 60 and 61 now – well done for this. The work of AIMS has been phenomenal and has made remarkable inroads in maternity for the rights of women and for the betterment of women's childbirth journeys.

Currently, many women and in particular women from the BAME backgrounds are experiencing horrendous inequalities and it would be great to see AIMS further engage and strengthen its work with women from the BAME communities, ensuring that their voices are really heard and acted upon.

I wish AIMS all the best to keep the impetus and energy to champion and astutely drive the change to improve maternity services.Thank you for giving me this opportunity to share my thoughts with you.

*An interview with Dr Kuldip Bharj, OBE, who has spent over 40 years of her career in midwifery, including roles in education, research and practice.*

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**"I would like to see 'personalised care' become a reality for women, where they experience kind, compassionate and respectful care."**

Article

# Comment on MBRRACE-UK 2019 Perinatal Confidential Enquiry: Stillbirths and neonatal deaths in twin pregnancies

*by Shane Ridley*

In my role in the Publications team, I was responsible for publishing a new *AIMS Guide to Twins Pregnancy & Birth* which is now available through the AIMS website: *www.aims.org.uk/shop/item/aims-guide-to-twin-pregnancy-birth*. The book frequently mentions the specialist team, including obstetrician, midwife and sonographer all of whom will have training in twin pregnancies and birth, and who will care for those who are pregnant with twins. Generally, AIMS Guides should reflect what the current practice is in the maternity services, based on the various guidelines, policies, evidence and experiences.

I wondered whether the book over-emphasised the need for the specialist team, bearing in mind that the choice in how we are treated and what care we access is our decision. However, while the right to bodily autonomy holds in any situation, having read this book, the fully informed mother expecting twins would very likely welcome the guidance and support of the specialist team.

Imagine my shock, then, when nearing the completion of the publication process of this book, MBRRACE-UK released their 'Perinatal Confidential Enquiry: Stillbirths and Neonatal Deaths in Twin Pregnancies' report[1], with the consensus finding being that 'in just over half the pregnancies improvements in care were identified which may have made a difference to the outcome for the babies.'[2]

I can only say that the new AIMS Guide to Twins Pregnancy & Birth includes what SHOULD happen in a twin pregnancy, NOT what is universally current practice.

The MBRRACE-UK team report in the lay summary that 'around 740,000 babies are born every year in the UK, and 2 out of 64 babies born are twins,' so over 20,000 twins.[3] Twin pregnancies have higher risks for many reasons, including babies being born preterm. The report shows that '**much more could be done to reduce the risks for women and their babies, save lives and prevent physical, emotional and psychological harm for women and their families.'**[4]

The report focuses on **80** baby deaths in **50** twin pregnancies – of those, 54% of the care relating to the babies was poor, 'which may have affected the outcome,' with a massive 64% of poor care relating to the mother.[5] The report says that, 'for two fifths of women (20 of 50) care was not provided by a specialised multidisciplinary team as recommended by national guidance. For only 5 of the 50 women was care documented as including a specialist midwife and specialist sonographer involvement.'[6] This is completely contrary to the guidance published by NHS England, the National Institute for Health and Care Excellence (NICE), the Royal College of Obstetricians and Gynaecologists (RCOG), the Royal College of Midwives (RCM) and the College of Radiographers (CoR).

So, what are these organisations doing to ensure that the guidance they issue is being followed by Hospital Trusts, commissioners of services, obstetricians, midwives and sonographers? Why are the Nursing and Midwifery Council (NMC) and General Medical Council (GMC) not ensuring that registrants (midwives and doctors) keep their knowledge and skills up to date? Why aren't midwives and doctors recognising the limits of their competence and reporting their lack of training? This quote from the RCM press release given after the report was released addresses those questions:[7]

> *The number of baby deaths, even in twin pregnancies, is very small, but we know that twins are more likely to be stillborn or die soon after birth than babies from a pregnancy with one baby. The national guidance is there to prevent this, and it is on every maternity service to ensure that this guidance is followed. If there are barriers to this, whether due to staff shortages or lack of training, then those should be addressed.*

The lay report is very easy to read, but to get the full details, do read the full report (which I found very harrowing).[8] Below are

just a few of the findings from the reviews:

- Less than half the women were looked after by the specialist team recommended by all the agencies listed above.
- Senior obstetricians were not always available for every woman during labour and birth.
- Neonatal care doctors were not always available for parents when their babies were at risk of not surviving.
- Those pregnant with twins sharing one placenta were not referred to the highest level fetal medicine centre for specialist input into their care when there were signs of complications.
- Bereavement care is very poor.

As in previous MBRRACE reports, not every death is being reviewed by the hospitals, those that were reviewed were of poor quality. There is a clear CALL TO ACTION at the end of the report[9].

**Professionals should read the full report at www.npeu.ox.ac.uk/mbrrace-uk/reports, implement its recommendations and follow national guidance. If this were done, it is clear that future lives could be saved and national ambitions to reduce avoidable baby deaths might be achieved.**

MBRRACE-UK has developed a checklist with clear guidance: make sure there is a SPECIALIST team of midwives, doctors and sonographers for twin pregnancies and births. A second opinion can be sought if there is concern about the care you are receiving. The checklist is copied below together with details of further very specific support.

## What you should expect from your care – a checklist

✓ You should be seen in a specialist twins clinic run by a team of doctors, midwives and sonographers who have training and experience in twin pregnancies.

✓ You should be given a schedule of the appointments and scans at your first appointment. The importance of each one should be explained to you.

✓ The team should explain to you what to look out for if you go into labour early and what to do about it.

✓ If you think there is a problem during your pregnancy, or think you might be going into labour, you should be seen by a doctor experienced in the care of twin pregnancies. They should review you and are likely to scan your babies to check they are well.

✓ If you give birth and your babies are small or poorly, you and your partner should be asked about the care you would like them to be given, with advice from a neonatal care doctor. You should be involved in all decisions about what happens to them.

✓ If one or both of your babies sadly dies, you and your partner should be offered bereavement care and a referral for specialist support.

✓ If one or both of your babies sadly dies, you should be given clear information about consenting to a post-mortem and how it might help you understand why they died.

✓ If one or both of your babies sadly dies, a hospital review of what happened should take place, with input from all the hospitals where you and your babies received care. This is a review of whether your care was adequate for your circumstances. You should be informed and asked if you have any questions or would like to provide your perspective of your care.

## Further support

- » If you have a concern about your care, raise it with the team looking after you.
- » Every hospital has a Patient Advice and Liaison Service (PALS) who can help you if you do not feel you are being listened to.
- » If you want independent advice about your care, these charities have helplines and support teams you can contact and information and resources you can use:
  - **Twins Trust** supports families with twins, triplets and more: www.twinstrust.org
    **Multiple Births Foundation** supports families with twins, triplets and more: www.multiplebirths.org.uk
  - **Bliss** supports families whose baby is born sick or too soon: www.bliss.org.uk
    **Sands** is a charity supporting families whose baby has died: www.sands.org.uk

The new AIMS Guide to Twins Pregnancy & Birth is now available (principal author Rebecca Freckleton) and the AIMS Guide to Resolution After Birth may help you if you have had poor care and/or a bereavement. Both are available from www.aims.org.uk/shop.

## Action YOU can take NOW

If you are concerned about specialist services in your area, raise it first with your local Maternity Voices Partnership (MVP), a team comprising service users (people like you), their families, commissioners and providers (including midwives and doctors) who are working together to review and contribute to the development of local maternity care. AIMS has more information on how to find these groups here: www.aims.org.uk/journal/item/mvps-are-key.

*Shane Ridley has volunteered for AIMS for over 20 years. She is responsible for publishing AIMS books and is also an AIMS Trustee. Trustee and Publications Team, May 2021*

ENDNOTES for MBRRACE article:

1 Draper ES, et al. (eds.) on behalf of MBRRACE-UK (2021). MBRRACE-UK 2019 Perinatal Confidential Enquiry: Stillbirths and neonatal deaths in twin pregnancies. The Infant Mortality and Morbidity Studies, Department of Health Sciences, University of Leicester: Leicester. www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/perinatal-report-2020-twins/MBRRACE-UK_Twin_Pregnancies_Confidential_Enquiry.pdf

2 Ibid.

3 MBRRACE-UK, 'Learning from deaths in twin pregnancies: Lay summary': www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/perinatal-report-2020-twins/Learning_from_deaths_in_twin_pregnancies.pdf.

4 Ibid.

5 Ibid.

6 Draper et al (2021).

7 Royal College of Midwives, 'National guidance key to reducing baby deaths in twin pregnancy, says RCM': www.rcm.org.uk/media-releases/2020/december/national-guidance-key-to-reducing-baby-deaths-in-twin-pregnancy-says-rcm.

8 MBRRACE-UK, 'Learning from deaths in twin pregnancies: Lay summary': www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/perinatal-report-2020-twins/Learning_from_deaths_in_twin_pregnancies.pdf.

9 Ibid.

10 Ibid.

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Article

# Where next for Better Births in England? Baroness Julia Cumberlege looks to the future

*by the AIMS Campaigns Team*

At the end of March, AIMS Volunteers were pleased to attend the NHS England national half-day Better Births Five Years On event. This year the event was inevitably online, but it still managed to retain a very familiar feel. It was hosted by Sarah-Jane Marsh (chair of the Maternity Transformation Board), and an easy-to-use Q&A and polling app allowed for a small amount of audience participation. The event offered a wide range of updates to illustrate the many areas that the Maternity Transformation Programme has focused on since the publication of Better Births in 2016. One striking element of this year's event was the presentations from each of the regional chief midwives, demonstrating the crucial investment in midwifery leadership being overseen by Jacqueline Dunkley-Bent (England's Chief Midwifery Officer). Their presentations were each themed around one of the essential and immediate actions set out in Donna Ockenden's interim report,[1] and they illustrated the benefits of a national maternity service in which good practice is effectively shared and lessons quickly learnt.

Disappointingly for the AIMS Campaigns Team, the day was not accompanied by the publication of a definitive report on the progress made so far against each of the Better Births recommendations. We trust that this will be produced soon. But the tone of the day was encouraging nonetheless. Particularly welcome was Julia Cumberlege's speech, marking the transition from this first five-year part of the programme to its next stage, which showed no sign of relinquishing the recommendations of the Better Births report.

We asked Julia for permission to share her speech, and she has allowed us to reproduce it here. In this speech, she focuses on what we need to take with us on the next stage of the maternity transformation journey, and what we might gladly leave behind. In doing so, she brilliantly captures so many of the key issues that are at the heart of the transformation we need to see, but also the huge team effort that has been undertaken – and that remains necessary – to turn the Better Births vision into a reality. For our part, the AIMS Campaigns Team pledges to be part of that ongoing effort, and we look forward to playing our part over the next five years.

## Julia Cumberlege's address to the Better Births Five Years On conference, 30 March 2021

We have been through a horrendous year of the pandemic but now we have a rare opportunity to think differently, into a new emerging maternity world. What should we take with us? What should we leave behind?

> *Well let's leave behind bureaucracy, unnecessary bureaucratic systems, structures. Go into our new world, slim, efficient, competent but not weighed down by all that stuff – stuff which intervenes and takes midwives and their colleagues away from women, away from personal and safer care.*
>
> *Let's leave behind dysfunctional archaic computer systems. And instead take with us new modern technology which enables women not only to access their care records, but to use their mobiles and laptops etc. to converse with their midwife, to build their maternity plan, to chart their journey and give them – the birthing mothers – control over this unique and life changing event.*
>
> *Let's leave behind the maternity notes, the red book, and embrace Apps and new ways of communicating.*
>
> *Let's ditch the routines and policies which are not evidence based, which disrupt normal birth, which heighten anxiety for women, their families and staff.*
>
> *Let us leave behind the view that birth is solely a medical event, forgetting the all-important physiology which enriches the mother and baby's attachment. When things do go unavoidably wrong, let's act in a*

*timely manner, with skill and consent, whilst feeling empathy and showing compassion.*

*Let's leave behind labour and birth in stirrups, except where absolutely necessary. It's degrading for women and diminishes dignity.*

*Let us leave behind dysfunctional teams, hierarchies, and the misery of long shift systems, shifts without a break where work/life balance ends up as a joke.*

**Let us take with us the precious things:**

*A culture that recognises the hope, joy and potential of birth; pregnancy and birth as transformative, the future of our human race; birth, the start of life – a new life – a new beginning.*

*With care, let's pack and take with us continuity of carer. Let us enable women and their midwives, obstetricians, nurses, care staff, to really get to know each other, get to trust each other, value the bravery of the mother and share the delight of the family in their new arrival.*

*Let us pack and take with us a love of learning – embrace the challenge. The excitement of renewal. Sharing knowledge among teams, crossing professional boundaries, abandoning those silos. Working with the wider world: analysts, economists, and even lawyers.*

*Let's take Rapid Resolution and Redress, concentrating on avoidable harm and not the requirement to prove negligence and apportion blame. We can save vast sums of money and enhance safety.*

*Let us rejoice in the enlightenment of a fresh approach working to humanise birth.*

*Let us take with us the good practices – the community services, midwife-led units, stand-alone units, home births – giving women real choice.*

**And then, who do we take with us?**

*The Maternity Transformation Board and the national team: wizards at getting things done, fighting for more resources, more space, more time. Managing the constant pressure of working in a policy area with so many stakeholders, polarised views, media and political interest.*

*We need to take the Regional teams – the "engine rooms" which embrace all that is in Better Births – and are still working to make our 28 recommendations a reality.*

*The Local Maternity Systems which put maternity ahead of the game, now having to work out how they can be integrated with Care Systems and – in the new world – still be ahead of the game.*

*I want to take with me the Royal Colleges, now under one roof and closer together than they have ever been. The academics and the researchers.*

*I want to take with me all those women and their families, who – 5 years ago – we listened to, and we still do; women who tell us what it is really like, sometimes sad and tragic stories. But they have not given up, they see better ways forward.*

*I want to take with me all those skilled, competent, reliable, thoughtful and inspiring health professionals. People whose eyes light up when they tell me "we are on the cusp, the tipping point; we want to go further, we want the best personalised and safer services in the world; we want to match Sweden, the safest place to give birth in Europe".*

*I want to take with me the Stakeholder Council who so enrich our thinking, with the charities, National Maternity Voices and the innovators. I want to take with me the brightest and the best in our service.*

*I want to take all of you here today, because you have shown in the last tumultuous year how we can still provide services against all the odds, and who have gone beyond endurance, travelled the extra mile. And I want to thank you from the bottom of my heart.*

*Above all I want to take with me a copy of Better Births, to monitor and see the fulfilment of the 28 recommendations, because if we achieve that, our maternity services will not be Better Births, but the Very Best Births in the land.*

*Thank you.* ~~~

Reference:

1 GOV.UK, 'Ockenden review of maternity services at Shrewsbury and Telford Hospital NHS Trust': www.gov.uk/government/publications/ockenden-review-of-maternity-services-at-shrewsbury-and-telford-hospital-nhs-trust.

Campaign update

# Coronavirus and the maternity services

*by the AIMS Campaigns Team*

Throughout the pandemic, AIMS has been campaigning for the needs of maternity service users to be recognised and for NHS Trusts/Boards to ensure that any restrictions they impose are a proportionate response to the situation. You can find details of all our campaigning activities on the Coronavirus page on the campaigns section of our website.[1]

We have continued to update our 'Coronavirus and your maternity care' Birth Information page to reflect changes in national guidance, and also our template letters for people to send to their Trust/Board to ask for their support needs to be met. After hearing from our Helpline Volunteers of cases of parents being separated from their babies after birth, we added further information and a template letter specifically for parents of babies being cared for in a neonatal unit.

We have also regularly posted content on our social media platforms to maintain awareness of the issues.

In October 2020, AIMS was instrumental in bringing together the But Not Maternity Alliance. This is a group of campaigning organisations concerned about the impact that maternity service restrictions are having on the safety and wellbeing of pregnant women and people, their partners and other supporters. The group takes its name from the #ButNotMaternity campaign started by doulas from The Birthbliss Academy in September 2020. It meets regularly to coordinate campaigning activities.

We were pleased to see updated guidelines published in all four nations of the UK towards the end of 2020 which, to varying degrees, encouraged Trusts and Boards to accommodate the support needs of maternity services users. (Details of the current guidance are available on our 'Coronavirus and your maternity care' Birth Information page.[5]) In particular, we welcomed the guidance in December from NHS England: Coronavirus » Supporting pregnant women using maternity services during the coronavirus pandemic: Actions for NHS providers.[6] This asked all NHS Trusts 'to urgently complete any further action needed so that partners can accompany women to all appointments and throughout birth' by undertaking risk assessments, making changes to their use of space and infection control measures, and using testing, including rapid testing.

Unfortunately, the publication of this guidance coincided with the arrival of the second wave of the pandemic, and this is likely to have delayed its implementation. Though there were signs that the challenges of lifting restrictions are being addressed by many Trusts and Boards, there continued to be huge variation across the UK, as this press release from the But Not Maternity Alliance explains.[7] As a result of our press release, the story was featured prominently in The Guardian over Easter.[8]

It seemed extraordinary that at a time when governments had set out plans to lift restrictions in almost all areas of life, maternity care should be the exception. The Alliance therefore wrote to Matt Hancock, Secretary of State for Health and Social Care, urging him to set out a roadmap for easing restrictions on partners and supporters in maternity services. Sadly, there has been no announcement on this so far.

At the same time, the But Not Maternity Alliance, together with National Maternity Voices, organised a webinar for MVP/MSLC user representatives to raise awareness of the national picture on maternity service restrictions, share best practice at local level and identify what needs to happen at the national level to enable the lifting of restrictions. You can read the report of the meeting here.[9] Following this, the Alliance wrote to NHS England to highlight the key messages from the meeting:

- The need for a unified policy across England
- The need for more clarity around the 2m social distancing requirement being an aspiration but not a necessity
- The need for home testing of partners to be supported
- The need to publish evidence about the risk to staff and other service users of bringing back partners/visitors into different areas of maternity services, and how

much testing and vaccination reduces these risks

We were very pleased when in April 2021, NHS England updated their guidance to urge Trusts to use 'any available testing capacity (including the national rollout of lateral flow testing) to test women and their support people' and to 'treat support people who test negative as part of the team supporting the woman.' Data collated by the But Not Maternity Alliance shows that over 90% of Trusts in England were admitting partners to 12- and 20-week scans by the end of April, and almost three-quarters were admitting them to later scans and all antenatal appointments. Many Trusts had also updated their postnatal visiting hours, although there continued to be a great deal of variation in the amount of time that partners/supporters were allowed to be present during inductions and on the postnatal ward.

At the time of writing, the Alliance plans to continue lobbying for all hospitals in all four nations of the UK to make every effort to enable all pregnant women and people to have the support they need throughout their maternity journey. Meanwhile, we are considering what further campaigning we can do to encourage Trusts/Boards to 'Build Back Better' in terms of access for partners/supporters and to maintain the improvements they have made if we experience a third wave of the pandemic.

We were delighted – and flattered – to learn that the But Not Maternity Alliance was the first runner-up in the Best Coalition category of the Sheila McKechnie Foundation's National Campaigner Awards 2021. This award 'recognises campaigns led by multiple partners in ways which are creative, respectful and genuinely collaborative.' AIMS is proud to have played a leading role in this group, which shows what can be achieved when campaigning organisations work together. We hope this will be the first of many such collaborations.

1 AIMS, 'Coronavirus and the maternity services': www.aims.org.uk/campaigning/item/coronavirus.
2 AIMS, 'Coronavirus and your maternity care': www.aims.org.uk/information/item/coronavirus.
3 AIMS, 'Template letters to request support during the coronavirus pandemic': www.aims.org.uk/information/item/aims-template-letters.
4 AIMS, 'When your Trust is refusing/limiting access to your baby in Neonatal Care': www.aims.org.uk/information/item/aims-template-letters#post-heading-4.
5 AIMS, 'Coronavirus and your maternity care': www.aims.org.uk/information/item/coronavirus.
6 NHS England, 'Supporting pregnant women using maternity services during the coronavirus pandemic: Actions for NHS providers': www.england.nhs.uk/coronavirus/publication/supporting-pregnant-women-using-maternity-services-during-the-coronavirus-pandemic-actions-for-nhs-providers/.
7 But Not Maternity Alliance, 'We have roadmap for the nation But Not For Maternity': www.aims.org.uk/assets/media/647/press-release-but-not-maternity-march-2021.pdf.
8 The Guardian, 'Plea to ease Covid maternity rules as women continue to get bad news alone': www.theguardian.com/lifeandstyle/2021/apr/04/plea-to-ease-covid-maternity-rules-as-women-continue-to-get-bad-news-alone.
9 But Not Maternity webinar on easing visitor restrictions for Maternity Voices Partnership members, 22 March 2021: www.aims.org.uk/assets/media/643/but-not-maternity-and-national-maternity-voices-webinar-on-easing-visitor-restrictions.pdf.

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# Film Review

## Review of the Spanish documentary

# Birth in the 21st Century

*by Rachel Boldero*

***Birth in the 21st Century*** **is a Spanish documentary produced by a Spanish television company with English subtitles. It has five episodes with an option to visualise detailed graphics on birthing statistics in Spain by clicking on a magnifying glass icon on the screen. There are prompts to help you to develop your own birth plan in English, which can also be downloaded. It is an informative documentary for anyone interested in birth and includes a separate section on birthing during the Covid-19 pandemic. It is easily accessible at** http://lab.rtve.es/webdocs/parto-respetado/en/expectations/.
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*Birth in the 21st Century* is a Spanish documentary following five families from the antenatal period through labour and birth and also into the postnatal period. Two families are first-time births and all five mothers birth their babies vaginally in a hospital setting. One family experienced birthing during the Covid-19 pandemic. Whilst this film was primarily produced for a Spanish audience, it is also great to celebrate the range of birth resources available outside the UK, albeit with some important caveats.

The births shown are beautiful and the film strikes a fairly good balance, depicting a natural and gentle birth coupled with the discomfort that some women experience. The bond between mother and baby is also gorgeous throughout. I like how the film is split into clear sections with pop-ups about options for developing an individualised birth plan. There is also the option to look at flashy graphics on Spanish birth statistics for those interested in caesarean birth, induction and episiotomies. However, I believe there are some fundamentals missing, which I will expand upon below.

I love how calm the women are (particularly at the beginning of the film) and how well they are supported by their families. Despite research showing that birthing people in Spain report high levels of obstetric violence, it is clear that hospital is viewed as a safe place: the film mentions that some of the women wanted to go to hospital so that they could 'safely' have their baby. I view this as a positive, as we want to eradicate as much fear from birth as possible, ensuring that we are not inhibiting those fundamental hormones needed for the birthing process such as oxytocin. However, there is no mention of birthing at home or in other non-hospital-based settings as a safe option. Also, the mode of birth is one-dimensional, showing only spontaneous vaginal births.

Another positive aspect for me is seeing how the midwives interact with those giving birth, ensuring they are kept fully informed and obtaining consent before carrying out any examinations. I appreciate the midwives' attitude and the language they use throughout the film, e.g., 'we don't need to know yet' in terms of whether the woman could feel the head, 'you know better than I,' 'you need to do what your body asks you to do,' 'you are in control.' As a student midwife, I really embrace such phrases and strive to mirror them in practice. This theme also plays into the pop-up messages, prompting women to consider things like what position they want to be in when giving birth.

I enjoyed how delayed cord clamping, skin-to-skin and the administration of vitamin K feature, and whilst this is now generally commonplace, I think it is useful to draw the viewer's attention to such aspects of the period immediately post birth so that they can consider their own wishes. It is also great that the third stage of labour is covered, which is sometimes missed from birthing information and again prompts the viewer to consider this for themselves. Breastfeeding is also depicted positively, and I found it refreshing that in one scenario the baby took some time to get used to this, highlighting that it can require patience on occasion and again preparing the viewer for what may be to come – it's not always the easiest of rides!

However, there are some aspects of the film I'm not so keen on. It is always a challenge to make a resource that completely covers all aspects of birth, but this film concentrates only on spontaneous vaginal births and babies who breastfeed. It might be more realistic to actually see caesarean birth, induction and bottle-feeding and also to have same-sex couples represented.

In addition, I feel that some elements of the birthing and postnatal period are glossed over. In reality, some women are shocked by the birthing process or feel low in the days and weeks afterwards. Perineal tearing is also a common aspect of birth and is only mentioned very briefly, yet for some women this can be pivotal. As always, it's a delicate balance of setting families up for a positive birth, but ensuring individuals are aware of possibilities and being encouraged to be open-minded about some things so they are better informed and more able to cope emotionally and physically.

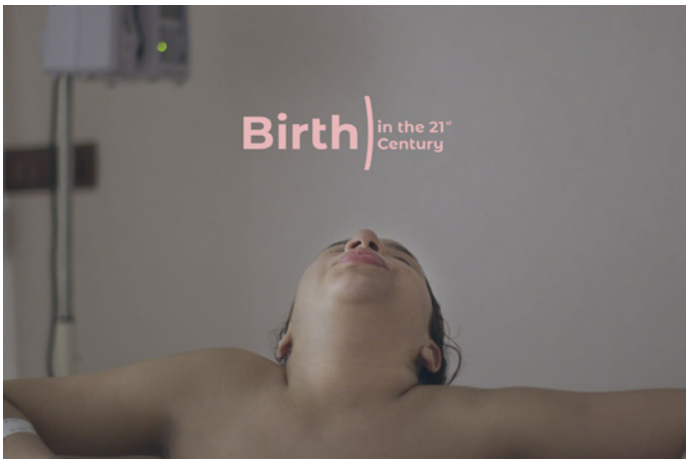
The film is not set in the UK and it goes without saying that there are some elements that I wouldn't be as comfortable witnessing in practice. For example, one of the women is hooked up to a CTG (cardiotocography medical assessment of baby's heartbeat and the uterine contractions) immediately upon admission; there may be a reason, but it isn't made clear. She had been coping well in an upright standing position but doesn't look at all comfortable attached to a CTG in the chair, which is such a shame. Furthermore, one of the midwives appears to apply a considerable amount of pressure directly to the baby's head

during the birth. I believe this was probably a bid to prevent tearing; however, the evidence on whether or not 'guarding the perineum' is of benefit is still not clear.

Overall, however, I really enjoyed this film. I love the format and the positive focus on birth, which can and should absolutely be an empowering process. The film reiterates the overwhelming joy that a baby brings to a family, prompts viewers to consider many useful aspects for their birth plan and includes some incredibly cute babies! I think it's a positive resource to encourage those in the antenatal period to consider aspects for their birth plan, reiterating the incredible process of birth along the way.

*Biography:*

*Hi, a little about me! My name is Rachel and I'm an AIMS Volunteer who decided to pursue a pretty drastic career change last year to become a midwife. I'm now nearing the end of my first year of training in South Yorkshire and am absolutely loving it. I'm always keen to review resources aimed at pregnant women/people and their families and was really pleased to watch Birth in the 21st Century.*

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Film Review

# Pieces of a Woman

Director: Kornél Mundruczó
Writer: Kata Wéber

*by Megan Disley*

SPOILER ALERT: This review describes the plot of the film in some detail.

Birth featured on film can often be depicted in an unrealistic way, or cause controversy. *Pieces of a Woman*, directed by Kornél Mundruczó, has certainly sparked a great deal of conversation – and even uproar – within the birthing community. The film depicts a deeply personal story of a new mother's home birth which ends in unfathomable tragedy. Martha (Vanessa Kirby) begins a year-long odyssey of mourning which fractures relationships with loved ones whilst she learns how to live alongside her loss.

I know when the film was first suggested to me with a brief synopsis I immediately had my reservations given the topic, and for a while I didn't wish to watch it at all. I wondered how it could possibly be anything but scaremongering and how it could possibly help to change common misconceptions around home birth, particularly as it is set in an American city where the role of the midwife is still largely misunderstood and a more medical model of care
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is preferred. However, after hearing it discussed on various platforms, I gave it a go and quickly came to realise it was much more than its intense opening and devastating tragedy suggests.

The film begins with Sean (Shia LaBeouf) working as an engineer on a bridge build, the two ends working towards completion in the middle.

The twenty-four-minute, continuous, real-time birthing scene was filmed all in one shot, taking the viewer with Martha and Sean throughout their entire journey in a very personal way, making the tragic end result even more gut-wrenching.

The birth scene starts out with the couple's midwife being unable to attend as she is in the middle of assisting another birth, so Eva is sent as a replacement. A couple of points I noted were the lack of the continuous request for consent from Eva and Martha having to wait to be told when she could push. Watching the film a second time around, I noticed it more and it really made me feel uncomfortable, particularly having knowledge of birth rights. If seen by a viewer who doesn't have this knowledge, there is a risk that this behaviour will be seen as the norm, something we should be moving well away from.

We are immersed in the birth scene right along with Martha, as the score washes over us as if we are underwater, embryonic even. The sounds and movements of the scene create a wave, from the crescendo of Martha's writhing on the floor to the collapse of the couple's calm embrace in the bath, just like the contractions themselves.

When tragedy strikes, the camera leaves the focus of what was a calming environment and begins to follow the chaos until it sets on the flashing lights of the parked ambulance. The focus never fully returns to the scene after that: the viewer is always left on the edge of the scene as to signify the turmoil and mourning that we are witnessing and the couple's inability to let one another in.

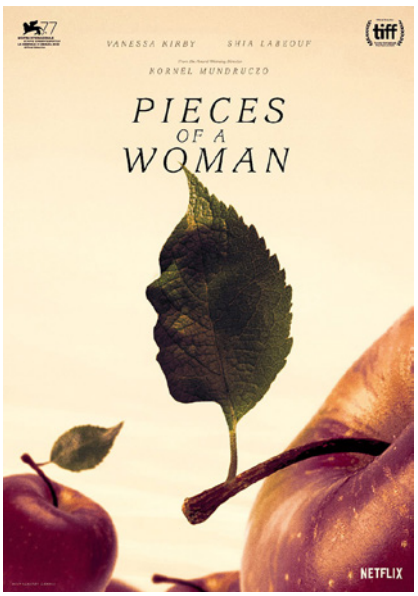
As time goes on, this is signified by the progress of the bridge being built. The pieces of the bridge are/seem eager to meet in the middle, whilst the couple tries to piece together what happened to their daughter, to work through their grief, and to rebuild their relationship.

There are other moments of symbolism entwined throughout the film, the most notable of them all being the apple, a symbol of fertility. It appears during encounters with a parent and child. Martha notes later on that her daughter smelt like an apple. She takes the seeds from an apple core and nurtures them. In the final moments of the film, she checks on the seedlings and finds that they have begun to sprout. From this moment, Martha begins to reconnect with those around her.

We don't ever come to understand what happened to Yvette, the baby daughter. We do know that a civil suit was started against Eva, reminiscent of witch-hunts against midwives.

The viewer is left with a bittersweet ending. Martha is seen scattering the ashes of her daughter on the very bridge that Sean helped to build. As we watch the ashes disappear into the river below, the scene dissolves into that of a little girl walking through a meadow to climb an apple tree, before Martha calls her name and the two go inside together. In this way, the two sisters are symbolically connected.

Overall, although there were moments during the labour scene and enquiry that have left me with unanswered questions, I wonder if this is a deliberate move by the filmmakers to add empathy to Martha and Sean's tragic loss. This is a very raw and real take on infant loss, and well worth a watch.




*Pieces of a Woman* is available to stream on Netflix.

**Bio:** *Megan is just beginning her journey as a student midwife and advocate for birthing people. She volunteers for AIMS on the Birth Information and Health Inequalities Teams. She lives in Essex with her young son.*

# What has the AIMS campaigns team been doing?

### What we've been up to this quarter!

The Campaigns Steering Group continues to work alongside the other teams in AIMS, including the Social Media, Birth Information, Helpline and Journal teams, and to network with other campaigners to focus on improving maternity services during the **#covid19 pandemic**. This includes regular coalition meetings with the But Not Maternity Alliance and the ongoing maintenance of the birth information pages and campaigns sections of the AIMS website.

Our activity focus has been on developing a series of **AIMS position papers**, as an important resource for AIMS Volunteers and other birth activists. These cover key outstanding areas for maternity service improvements, together with an AIMS view on the issues and what needs to change. Initial papers on Freebirthing, Choice of Place of Birth, Decision Making in Maternity and Continuity of Carer will be published shortly. There are more under development, including Obstetric Violence and Health Inequalities and Maternity Services. We'd be interested to hear from our readers what else you want us to cover.

AIMS Volunteers have come together to focus on:

- **Obstetric violence** – the pop-up group came together to urge the government's Violence Against Women and Girls strategy review team to include the issue of **obstetric violence**. You can read our submission together with a brief explanation of what obstetric violence is here.[1]
- **Health inequalities and the maternity services** – a pop-up group is developing our understanding of the issues that drive inequalities in outcomes and how AIMS should campaign on this issue.
- Draft NICE Guidelines on Antenatal Care[2]
- Draft RCOG Patient Information[3] – Considering a Caesarean Birth
- The government's Violence Against Women and Girls strategy review – see above
- The Health and Social Care Committee for England's Expert Panel, which is evaluating the government's commitments in the area of maternity services in England[4]

As part of the But Not Maternity Alliance, the campaigns team:

- Drafted a template letter for concerned individuals to send to Trusts who have yet to publish plans on lifting restrictions[5]
- Issued a joint press release calling on the government to add maternity to the roadmap to normality[6]
- Wrote a joint letter to Secretary of State for Health & Social Care asking for a response to this call[7]
- Held a joint meeting with National Maternity Voices bringing together MVP reps[8] from across England plus Wales and Scotland to share best practice and identify what is required at a national level
- Wrote a joint letter to NHS England sharing the key messages from this meeting[9]

1 AIMS, 'AIMS Submission to the Violence Against Women and Girls call for evidence': www.aims.org.uk/campaigning/item/violence-against-women-and-girls.

2 National Institute for Health and Clinical Excellence, 'Guidelines on Antenatal Care': www.nice.org.uk/guidance/indevelopment/gid-ng10096.

3 Royal College of Obstetricians and Gynaecologists, 'Patient Information for Consultation': www.rcog.org.uk/en/patients/patient-leaflets/developing-patient-information/.

4 House of Commons Committees, 'The Health and Social Care Committee's Expert Panel': https://houseofcommons.shorthandstories.com/health-and-social-care-committee-expert-panel/.

5 AIMS, 'Template Letter for campaigning about Maternity Services during the pandemic': www.aims.org.uk/campaigning/item/template-letters.

6 AIMS, 'We have a roadmap for the nation But Not Maternity': www.aims.org.uk/campaigning/item/we-have-a-roadmap-for-the-nation-but-not-maternity.

7 AIMS, 'Letter to Secretary of State for Health and Social Care': www.aims.org.uk/assets/media/645/letter-to-matt-hancock-1-april-final.pdf.

8 AIMS, 'But Not Maternity/National Maternity Voices Webinar 22nd March 2021': www.aims.org.uk/campaigning/item/but-not-maternity-national-maternity-voices-webinar-22nd-march-2021.

9 AIMS, 'Joint letter to NHS England': www.aims.org.uk/assets/media/646/letter-to-nhse-1-april-2021-final.pdf.

**Conferences and meetings we have attended include:**

- A midwifery unit network meeting to discuss **#ContinuityofCarer** and its impact on core staff for MLUs in the UK
- Regular meetings of the NHS-E-organised **Maternity Transformation Programme Stakeholder Council**
- The RCOG-hosted **Each Baby Counts** full-day event
- An online webinar launching **NICE**'s new five-year strategy
- **Maternity & Midwifery Hour** online meetings, which have recently focussed on various topics including the latest MBRRACE-UK report, postnatal care and cultural safety in the maternity services. You can read more about this series of meetings here: www.maternityandmidwifery.co.uk/the-maternity-and-midwifery-hour/
- An online conference focussed on poor maternity outcomes for Black women and families organised by the Manchester-based Caribbean and African Health Network (CAHN) www.cahn.org.uk,[10] which was attended by AIMS Volunteers in order to celebrate **International Women's Day** (March 8th)
- A regular **Baby Feeding Law Group** (BFLG) meeting
- The **Better Births Five Years On** conference (BB5YO) organised by NHS England
- A joint **webinar on maternity restrictions** organised by the But Not Maternity Alliance and National Maternity Voices

**What we've been reading:**

- The **Safer Maternity Care Progress Report** 2021 – published in time for the #5YrsBetterOn Event. This is well worth a read by all birth activists, as it contains a reasonable update on what's been achieved to date by the Maternity Transformation Programme (whilst falling short of a full implementation update for each of the Better Births recommendations and overall vision!). Find it here: www.england.nhs.uk/wp-content/uploads/2021/03/agenda-item-9.4-safer-maternity-care-progress-report-2021-amended.pdf
- NHS-E's new guidance on Personalised Care[11]
- Each Baby Counts: 2020 final progress report (www.rcog.org.uk/en/guidelines-research-service)[12]
- Rachel Reed's new book, *Reclaiming Birth as a Rite of Passage*

**What we've been watching:**

*Birth in the 21st Century* – a Spanish documentary (with English subtitles!) which would be worth a watch by anyone interested in birth.[13] It includes an interesting separate section on birthing during the Covid-19 pandemic**.**

We are also joining in Volunteer meetings, continue with our weekly Campaigns Steering Group meetings and work towards our approved quarterly action plan.

Thanks to all the AIMS campaigns Volunteers who have made all this work possible. We are very keen to expand our campaigns team, so please do get in touch with campaigns@aims.org.uk if you'd like to help!

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10 CAHH – Caribbean and African Health Network homepage: www.cahn.org.uk/.

11 NHS England, 'Personalised care': www.england.nhs.uk/personalisedcare/.

12 Each Baby Counts, '2020 final progress report': www.rcog.org.uk/en/guidelines-research-services/audit-quality-improvement/each-baby-counts/reports-updates/2020-report/.

13 Birth in the 21st Century: http://lab.rtve.es/webdocs/parto-respetado/en/prenatal/.
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